Commonwealth of Massachusetts

Member Handbook

Effective July 1, 2004

FALLON COMMUNITY HEALTH PLAN

If you need an interpreter to understand our procedures when doing business with the health plan, we will make the arrangements for interpreter or translation services.

إذا كنت بحاجة إلى مترجم فوري لفهم إجراءاتنا عند التعامل مع الخطة الصحية، فسنتخذ الترتيبات اللازمة لنؤمّن لك مترجما فوريا أو خدمات ترجمة.

បើអ្នកត្រូវការអ្នកបកប្រែដើម្បីឲ្យយល់អំពីដំណើរការរបស់យើងនៅពេលធ្វើការងារទាក់ទងជាមួយគំរោងសុខភាព យើងនឹងរៀបចំអ្នកបកប្រែឬកិច្ចបំរើខាងការបកប្រែ ។

Si ou bezwen entèprèt pou ou kapab konprann ki sa pou ou fè lè wap regle nenpòt bagay avèk plan de sante a, nap fè aranjman pou ou jwenn entèprèt oswa sèvis tradiksyon.

ຕ້ອງການນາຍພາສາ ເພື່ອທີ່ຈະເຂົ້າໃຈການດຳເນີນ ວຽກງານທັງຫຼາຍຂອງພວກເຮົາ ເວລາຕິດຕໍ່ວຽກງານ ກັບແຜນປິ່ນປົວສຸຂະພາບ, ພວກເຮົາຈະຈັດຫາບໍລິການແປພາສາໃຫ້ ແບບປາກເປົ່າຫຼືແບບຂຽນ.

Если Вам нужен переводчик, чтобы понять нашу политику, когда Вы имеете дело с планом медицинских услуг, то мы предоставим устного переводчика или услуги письменного перевода.

Si necesita un intérprete para comprender nuestros procedimientos al negociar su plan de salud, solicitaremos los servicios de un intérprete o traductor.

Quando estiver tratando do plano de saúde e por acaso necessitar de um intérprete para melhor entender os nossos procedimentos, nós podemos planejar os serviços de interpretação ou de tradução necessários.

If you need an interpreter to understand our procedures when doing business with the health plan, we will make the arrangements for interpreter or translation services.

Qualora aveste bisogno di un interprete per meglio comprendere le nostre direttive e le indicazioni del piano preventivo, saremo lieti di assistervi con servizi di interpretariato e traduzione.

Αν χρειάζεστε τις υπηρεσίες διερμηνέα για να καταλάβετε τις διαδικασίες μας όταν εργάζεστε με το πλάνο υγείας, θα κανονίσουμε ώστε να υπάρχουν διαθέσιμες υπηρεσίες διερμηνέα ή μεταφραστή.

Si vous avez besoin d'un interprète pour comprendre nos procédures dans le cadre du plan médical, nous prendrons les dispositions nécessaires pour obtenir les services d'un interprète ou d'un traducteur.

當您與本健保計劃接洽生意時，如果您須要口譯員協助您了解我們的程序，我們會安排口譯或翻譯服務。

Jeśli będzie Pan(i) potrzebował(a) tłumacza, ażeby zorientować się w naszym postępowaniu przy kontaktach z przedstawicielami planu ubezpieczenia medycznego, my załatwimy tłumaczenie lub przekład.

Nếu quí vị cần người thông dịch để hiểu rõ các thể thức của chúng tôi khi liên hệ thương mại về hợp đồng y tế, chúng tôi sẽ sắp xếp để có các dịch vụ thông dịch hay phiên dịch.

Welcome!

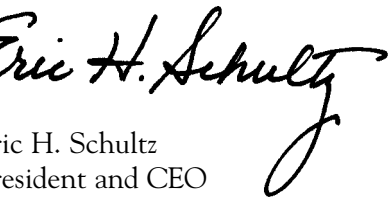
Thank you for choosing Fallon Community Health Plan, Inc. (FCHP) for your health care coverage.

You've joined one of America's foremost health maintenance organizations. We have a national reputation for quality and service and have earned the National Committee for Quality Assurance's (NCQA) Excellent Accreditation status for both our commercial and Medicare plans.

This *Member Handbook*, along with its addendum, describes the benefits and other terms of coverage for persons enrolled through the Group Insurance Commission. The addendum contains the benefits particular to the FCHP plan you have joined, either Select Care or Direct Care. Those who may join FCHP include eligible employees of the Commonwealth of Massachusetts, Elderly Governmental Retirees (EGRs), Retired Municipal Teachers (RMTs) and retirees not eligible for Medicare.

If you have any questions regarding this *Member Handbook*, please call FCHP Customer Service at 1-866-344-4GIC (TTY/TDD 1-877-608-7677).

Once again, thank you for choosing Fallon Community Health Plan. We look forward to serving you.



Eric H. Schultz
President and CEO
Fallon Community Health Plan, Inc.

Table of contents

This section contains:

Definitions

Anniversary date: The date each year when most major changes to your health plan take effect. Group health plans usually allow subscribers to switch health plans during a designated "open enrollment" period prior to the anniversary date.

Authorization: An assurance by the plan to pay for medically necessary covered benefits provided by a network provider for an eligible plan member. In some instances, PCPs are given authority to issue an authorization for specialty care.

Calendar year: The 12-month period beginning on January 1 and ending on December 31.

Coinsurance: Your share of the allowed charge for certain covered benefits according to the fixed percentage specified in the "Coinsurance" section on page 74.

Commission: The Group Insurance Commission, the agency of the Commonwealth of Massachusetts which administers your group health plan. Also referred to as "plan sponsor."

Contract: The agreement that FCHP has with the Group Insurance Commission to provide benefits to you and your covered dependents.

Copayment: The amount you are responsible to pay for certain covered services. The copayment amounts for services are listed in the addendum enclosed in this *Member Handbook*.

Covered services: Health care services or supplies that are covered by the plan, as described in this *Member Handbook*.

Custodial care: A level of care which: (1) is chiefly designed to assist a person with the activities of daily life, and (2) cannot reasonably be expected to improve a medical condition. Custodial care is not covered by the plan.

Effective date: The date, determined by the Commission, on which your coverage begins.

Emergency medical condition: A medical condition, whether physical or mental, manifesting itself by symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of prompt medical attention to result in: (1) serious jeopardy to the health of the member or another person, or, in the case of a pregnant woman, the health of the woman or her unborn child; (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part.

Emergency services: Inpatient and outpatient services, whether inside or outside the plan service area, that are: (1) furnished by a qualified provider and (2) needed to evaluate or stabilize an emergency medical condition.

Facility: A licensed institution providing health care services or a health care setting, including, but not limited to, hospitals and other inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory and imaging centers, and rehabilitation and other therapeutic health settings.

FCHP: Fallon Community Health Plan, Inc. (also referred to as "the plan," "us," "we" and "our").

FCHP Independent Care: A health insurance plan offered by Fallon Community Health Plan that is issued to any eligible individual and his/her dependents regardless of age, occupation, actual or expected health condition, claims experience, duration of coverage or medical condition (also referred to as "guaranteed issue health plan").

Group: The Commission's program to provide health coverage, in which FCHP is a participating vendor.

Health care professional: A physician or other health care practitioner licensed, accredited or certified to perform specified health services consistent with law.

Inpatient: A registered bed patient in a licensed hospital or other facility.

Medically necessary service: A service or supply that is consistent with generally accepted principles of professional medical practice, as determined by whether or not: (1) the service is the most appropriate available supply or level of service for the insured in question, considering potential benefits and harms to the individual; (2) the service is known to be effective, based on scientific evidence, professional standards and expert opinion, in improving health outcomes; (3) the service is based on scientific evidence, in the case of a service or intervention not in widespread use.

Member: Any person who has the right to services under this plan, which includes the subscriber and any family members covered under the subscriber's contract (also referred to as "you").

Network provider: A licensed physician or other healthcare professional, or hospital or other healthcare facility, whom we contract to provide covered benefits to plan members. This includes, but is not limited to, physicians, chiropractors, optometrists, podiatrists, certified nurse midwives, certified registered nurse anesthetists, nurse practitioners, and behavioral health professionals.

Nongroup membership: Your membership if you are not a member through a group. You pay your premium charge directly to FCHP. FCHP Independent Care is an example of a nongroup plan.

Open enrollment: A designated period, just prior to a group's anniversary date, when group members may change to another health plan or make changes to their existing health care contract. Any changes made become effective on the anniversary date.

Outpatient: A patient who is not a registered bed patient in a hospital or other medical facility.

Peace of Mind Program™: A medical management program (also referred to as "POM") which provides access to specialty care services at specified Boston medical centers.

Plan: Fallon Community Health Plan, Inc. (also referred to as "us," "we," "our" and "FCHP").

Plan sponsor: The Group Insurance Commission, the organization that administers your group plan.

Premium charge: The amount charged by FCHP for the coverage provided under this contract (see page 46 for more information).

Primary care provider (PCP): A network provider, specializing in internal medicine, family practice or pediatrics, whom you choose to work with you to manage your medical care.

Referral: A recommendation by which a network provider sends a member to another network provider for services that are typically outside the referring provider's scope of practice. Since network providers are freely able to recommend treatment options without restraint from the plan, a referral in and of itself does not guarantee that a recommended treatment is a covered benefit or that the accepting provider is contracted with the plan, and does not obligate the plan to pay for the service.

Room and board: Your room, meals and general nursing services while you are an inpatient.

Subscriber: The person whose name the policy is in, or the employee who is enrolled in the plan.

Terminal illness: An illness as a result of which a member has a life expectancy of less than 6 months.

Urgent care: Medical care that is needed right away for minor emergencies, such as cuts that require stitches, a sprained ankle or abdominal pain.

About this Member Handbook

This *Member Handbook* is effective July 1, 2004. There are no waiting periods or pre-existing condition limitations under this contract. You may use the services described here beginning on July 1, 2004, or on your effective date, whichever comes later. We recommend that you read this *Member Handbook* and keep it in a safe place for future reference.

This *Member Handbook* details the benefits and services that FCHP covers for persons enrolled through the Group Insurance Commission, explains our policies and procedures and contains other information such as:

- Important points to remember about FCHP
- Our customer service capabilities
- The role of your PCP
- Referral and authorization procedures
- Your rights and responsibilities
- Types of coverage available
- Claims procedures
- Additional contract provisions
- Your plan benefits

When you joined FCHP, you chose either FCHP Direct Care or FCHP Select Care. If you chose FCHP Direct Care, you must use the providers in the FCHP Direct Care network. If you chose FCHP Select Care, you must use the providers in the FCHP Select Care network.

In addition to the general information provided in this *Member Handbook*, we have enclosed an addendum that contains additional information that is specific to the plan you have chosen. Please refer to the addendum for information such as the network service area and your copayments.

If we need to update or change this *Member Handbook*, we will send you an amendment.

If you have any questions regarding this *Member Handbook*, please call FCHP Customer Service at 1-866-344-4GIC (TDD/TTY: 1-877-608-7677).

Understanding your health care coverage

Fallon Community Health Plan (FCHP) is a health maintenance organization (HMO) that provides health care coverage for its members through a network of health care professionals and facilities. FCHP is incorporated under the laws of the Commonwealth of Massachusetts as a nonprofit organization, and qualifies under federal law as a health maintenance organization. Our administrative offices are located at Chestnut Place, 10 Chestnut Street, Worcester, Massachusetts 01608.

Understanding how your health plan works is important. For one thing, it helps you know what to expect. The following information highlights the most important points about how we work to ensure you receive quality care and services.

Important points to remember:

• When you join the plan, you select a primary care provider who coordinates your health care. (See "Choosing a primary care provider (PCP)" on pages 16 and 17.)

• In order for you to receive coverage for most services, care must be coordinated by your PCP and administered by a network provider. Network providers have an agreement to provide covered services to members of the plan.

• For most covered services, you should obtain a referral from your PCP, and in some cases, your PCP will obtain preauthorization from the health plan. (See "Obtaining specialty care and services" on pages 18 to 22.)

• FCHP maintains a prescription drug formulary. (See "The FCHP prescription drug formulary" on page 100.)

Your membership card

When you enrolled in the plan, we sent you a membership card for each covered family member. Please carry the card with you at all times. Many network providers will ask you to show your membership card when you seek medical care or fill a prescription.

You should receive your card within 30 days of the date that we receive and verify your enrollment request. If you do not receive a card, if the information on your card is incorrect, or if you lose or damage your card, call Customer Service.

Notifying us of changes

Call Customer Service and the Group Insurance Commission to report any changes in your name, address, phone number, number and status of dependents or any other pertinent information. If there is a change to your family status that would require a change in contract type (for example, you have an individual contract, but you marry or have children), request a change in status through the Group Insurance Commission within 60 days of the event.

Questions? Just ask.

Fallon Community Health Plan (FCHP) is committed to your satisfaction and helping you get the most from your plan membership. We offer many resources to help you, including a dedicated Customer Service and Consumer Affairs staff. If you have questions, call:

Customer Service
1-866-344-4GIC
(TDD/TTY: 1-877-608-7677)

For answers to general questions or inquiries
(See also pages 32 to 37, "Inquiries and grievances.")

For help in choosing or changing your PCP
(See also pages 16 and 17, "Choosing a primary care provider.")

With questions about your membership card
- If you do not receive a card
- If the information on your card is incorrect
- If you lose or damage your card

To notify the plan of changes
- To report any changes in your name, address, phone number, number of dependents, or any other pertinent information

To request materials, such as
- Additional copies of this *Member Handbook*
- A copy of the provider directory, which has a listing of network providers

You'll find information and answers to many of your questions and be able to perform a number of transactions at our Web site.

Our Web site, www.fchp.org

For information on FCHP's products and services, log on and visit us at www.fchp.org. Our Web site offers you a place to learn more about FCHP, as well as a convenient and secure way of communicating with us. Among other things, you can use the site to:

- Search our regularly updated provider directory
- View the prescription drug formulary
- Request a new membership card
- Change your address or phone number
- Change your primary care physician
- Contact Customer Service

You can also learn more about our preventive health care guidelines, health education classes and FCHP-sponsored community events. Can't find what you need online? Use our site search feature or contact the webmaster with your suggestions.

This section contains:

Choosing a primary care provider (PCP)

When you join Fallon Community Health Plan, you choose a network provider as your PCP. Your relationship with your PCP is very important, because he or she will work with the plan to provide or arrange most of your health care.

PCP choices

Each covered family member should choose his or her own PCP. This can be a:

- Family practice doctor (for members of all ages)
- Doctor of internal medicine (for members over 18)
- Pediatrician (for members under 18)
- In some circumstances, a physician assistant (P.A.) or nurse practitioner (N.P.) who works under the supervision of a plan physician

Our provider directory contains the names of providers who are available as PCPs, their addresses and admitting hospital(s). If you haven't selected a PCP and you don't have a provider directory, Customer Service will send you a copy. You can also visit our Web site at www.fchp.org to obtain names of network providers in your area.

Make an appointment

Once you have selected a PCP, it's a good idea to schedule an appointment. This will allow your PCP to learn about you and your medical history and to begin coordinating any medical care that you may need. He or she can also help you with questions on:

- Preventive care
- Prescriptions
- Specialty care referrals
- Urgent care services
- Management of your ongoing medical needs

Keep phone number handy

It's also a good idea to keep your PCP's telephone number in your wallet or by your phone. If you need to see someone right away, your PCP (or whoever is on call) will direct you. Network providers' telephones are answered 24 hours a day, 7 days a week for emergencies and urgent care needs, and there are always physicians on call.

Change any time

You can change your PCP at any time by calling Customer Service or using the Web site.

Obtaining specialty care and services

When you have health care concerns, a good place to start is by contacting your PCP. Much of the time your PCP can provide the care that you need. Sometimes, however, you may need specialty care or services that your PCP does not provide.

Self-referral

In some instances you can self-refer to a specialist. This means that you can call the specialist and make the appointment yourself. You do not need to have a referral from your PCP, but you must see a network provider.

Services you can self-refer for:

- All FCHP Direct Care members and only FCHP Select Care members with a Fallon Clinic PCP may self-refer for office visits with a Fallon Clinic specialist (physician, physician assistant, nurse midwife or nurse practitioner only).
- Office visits with an obstetrician, gynecologist, certified nurse-midwife or family practitioner for an annual preventive gynecological examination, including Pap smear and mammogram, and any subsequent services determined to be necessary as a result of such examinations; services for acute or emergent gynecological conditions; and maternity care. It does not include inpatient admissions or infertility treatment (unless provided by a Fallon Clinic specialist and you have a Fallon Clinic PCP; see pages 84 and 85 of this *Member Handbook* for more information on "Infertility/assisted reproductive technology services").
- Office visits to an oral surgeon for extraction of impacted teeth. (Note: visits to an oral surgeon for any other procedure require a referral and authorization. See the "Oral surgery" section on page 96 of this *Member Handbook* for more information on covered oral surgery services.)
- Routine eye examinations with an ophthalmologist or optometrist.
- Outpatient mental health and substance abuse services. For help in finding a network provider, call 1-888-421-8861 (TDD/TTY: 781-994-7660).

PCP referral

If you and your PCP decide that a visit with a specialist is medically necessary, he or she may refer you to a specialist.

For certain services your PCP is authorized to refer you to a specialist. Your PCP will submit a copy of the referral to FCHP and we will send you and the specialist a confirmation. If you get services from any doctor, hospital or other health care provider without getting a referral in advance from your PCP, you will have to pay for these services yourself.

Services that need a PCP referral, but do not need preauthorization from the plan:

- Office visits with a specialist (Note: All FCHP Direct Care members and only FCHP Select Care members with a Fallon Clinic PCP may self-refer for office visits with a Fallon Clinic specialist; see "Self-referral" on page 18). PCP referrals are valid for up to a maximum of 12 visits within a 12-month period. Your PCP has the discretion to allow fewer visits. The specialist must obtain preauthorization from the plan for all specialty services.
- Initial evaluation with a podiatrist for podiatry services. The podiatrist must obtain preauthorization from the plan for all subsequent visits.
- Chiropractic care. Your PCP will give you a referral to a chiropractor for up to five visits, if medically necessary. The chiropractor must obtain preauthorization from the plan for all subsequent visits.
- Physical, occupational and speech therapy. Your PCP will provide you with a written order to take to a physical, occupational or speech therapist. The written order covers up to six visits if medically necessary. The therapist must obtain preauthorization from the plan for all subsequent visits.

Plan preauthorization

For certain types of specialist visits and for certain specialty services, your PCP will need to get preauthorization from the plan before giving you a referral. Preauthorization is an assurance by the plan that we have approved medically necessary covered services.

When your PCP needs preauthorization from the plan, he or she will send a "Request for Authorization" to the plan. We will review the request and make an authorization decision within two business days of receipt of all the necessary information. For the purposes of this section, "necessary information" may include the results of any face-to-face clinical evaluation or second opinion that may be required. We will tell your PCP of our

decision within 24 hours of the time that we make the decision.

If we authorize the service, we will send you and your PCP an authorization letter within two business days thereafter. When you get the letter, you can call the specialist to make the appointment. If you do not get an authorization letter, you will be responsible for paying for the services.

The authorization letter will state the services the plan has approved for coverage. If the specialist feels you need services beyond those authorized, the specialist will ask for preauthorization directly from the plan. If we approve the request for additional services, we will send both you and your PCP an authorization letter.

If we do not authorize a service, we will send you and your PCP a denial letter within one business day of the decision. The denial letter will explain our reasons for the decision and your right to file a grievance.

For a list of services requiring preauthorization, see "Services that require plan preauthorization" in the enclosed addendum to this *Member Handbook*, or refer to the benefit charts on pages 76 to 122 for a description of the preauthorization requirements for covered services.

Please note: A referral is a recommendation from your PCP that you should receive a specialty service from another provider. Since network providers are freely able to recommend treatment options without restraint from the plan, a referral or treatment recommendation in and of itself does not guarantee that a referral or recommendation is a covered benefit or that the accepting provider is a network provider. Therefore, if your PCP refers you to a provider who is not a network provider, you will be financially responsible unless an authorization is issued by the plan. Services, supplies or equipment that are not described as covered in this *Member Handbook*, or that did not receive any necessary authorization, are not covered. Services, supplies and equipment for an individual who is not a member at the time services are rendered are not covered.

Emergency services

Emergency services (as defined on page 78) do not require referral or authorization. When you have an emergency medical condition you should go to the nearest emergency room or call your local emergency communications system (police, fire department, or 911). Although you do not need to obtain a referral or authorization for emergency care, you must notify the plan within 48 hours or as soon as is medically possible. For more information on emergency benefits and plan procedures for emergency services, see pages 78 to 79.

Peace of Mind Program™

FCHP's Peace of Mind Program™ provides access to specialty services at specified Boston area medical centers. You may access Peace of Mind Program™ providers at your request if you meet the following conditions:

- Care is for covered services as described in this *Member Handbook*. The same copayments and benefit limits apply.
- You have seen a network specialist for this condition within the past three months.
- A referral to a specific Peace of Mind Program™ provider is made by your PCP and notification is given to the plan that you are accessing that provider through the Peace of Mind Program.™
- The provider to whom you are referred is on staff at one of the six medical centers listed below:
  - Massachusetts General Hospital
  - Brigham and Women's Hospital
  - Children's Hospital (Boston)
  - Dana-Farber Cancer Institute
  - New England Medical Center
  - Boston IVF (for infertility services only)

If you receive any hospital-based services such as surgery, lab or X-rays, these services must be performed at one of the above hospitals. If you see a provider through the Peace of Mind Program,™ and the provider recommends or arranges services to be performed at a hospital that is not listed above, these services will not be covered unless the provider has obtained preauthorization from the plan. You must have a copy of the written authorization from the plan; do not rely on assurances by the provider regarding plan coverage.

Once the plan has been notified about the Peace of Mind Program™ referral, you may arrange an appointment to see this provider for a consultation. You may continue treatment with this provider or you may return to a network provider for care at any time, so long as you obtain appropriate authorization. If you wish to see any other Peace of Mind Program™ provider, you must request a separate referral from your PCP, the plan must be notified about this new referral, and you must meet all the conditions listed above.

You may use the Peace of Mind Program™ for all specialty care except mental health, substance abuse, chiropractic services, obstetrics or dental care. You may not use the Peace of Mind Program™ for any primary care services, including internal medicine, family practice or pediatrics. If you have not met the conditions listed above, the services will not be covered by the plan and the Peace of Mind Program™ provider may hold you financially responsible.

This section contains:

Medical management

Utilization review

FCHP's case management program reviews and evaluates the health care our members receive to make sure that our members' care is coordinated, and that appropriate levels of service are available to all members.

The program is staffed by licensed registered nurse case managers, physician reviewers and specialists who are in routine contact with our health care providers. They use national, evidence-based criteria that are reviewed annually by a committee of health plan and community-based physicians to determine the medical appropriateness of selected services requested by your physician. These criteria are approved as being consistent with generally accepted standards of medical practice, including prudent layperson standards for emergency room care.

FCHP also develops in-house criteria, making use of local specialist input and current medical literature, as well as guidelines from Medicare and the Commonwealth of Massachusetts.

To obtain information about the status or outcome of a utilization review decision, call 1-866-344-4GIC, extension 69915 (TDD/TTY: 1-877-608-7677).

Quality management

FCHP's Quality Assurance Program systematically measures, monitors, evaluates and improves the performance of the managed care organization with respect to clinical care and service received by its members. Components of the program include careful attention to credentialing and recredentialing of providers, evaluation of all member complaints related to quality of care, and a formal peer review program to identify opportunities for improved care (on both an individual-practitioner level and a system-wide level). The plan also conducts focused performance projects related to plan-specific opportunities and formal chronic disease management programs appropriate to the plan's membership. With respect to service quality, the plan monitors and assures appropriate access to its contracted practitioners. A team of physicians, licensed registered nurses, and specialists create and regularly update clinical guidelines that are then

shared with our contracted practitioners to promote preferred medical practices and to improve the quality of care. These guidelines are designed to complement rather than replace your doctor's clinical judgment.

Assessing new technologies

FCHP maintains a formal mechanism for evaluation of new medical technologies and devices through our Technology Assessment Committee. The committee includes physician administrators, practicing primary care or specialty physicians from the relevant field, and plan staff who perform extensive research regarding the proposed technology. We make use of external research organizations, which perform reviews of all the available literature regarding a given procedure.

The Technology Assessment Committee also reviews all pertinent policies from state and federal regulatory agencies regarding any mandates for coverage of specific procedures. The committee also performs its own literature searches as needed to assure that we have all of the available information pertinent to the topic in question. The committee recommends for health plan coverage those new procedures that can offer improved outcomes to our members without substantially increasing the risks of treatment. We have a separate but similar process for evaluation of new drugs and medications, with reviews performed by our Pharmacy and Therapeutics Committee.

This section contains:

Your Rights and Responsibilities

Member rights

As a Fallon Community Health Plan member, you have the right to …

Be informed about Fallon Community Health Plan and covered services.

Receive information about the managed care organization, its services, its practitioners and providers, and members' rights and responsibilities.

Be informed about how medical treatment decisions are made by the contracted medical group or Fallon Community Health Plan, including payment structure.

Choose a qualified contracted primary care physician and contracted hospital.

Know the names and qualifications of physicians and health care professionals involved in your medical treatment.

Receive information about an illness, the course of treatment and prospects for recovery in terms that you can understand.

Actively participate in decisions regarding your own health and treatment options, including the right to refuse treatment.

Receive emergency services when you, as a prudent layperson acting reasonably, would have believed that an emergency medical condition existed.

Candidly discuss appropriate or medically necessary treatment options for your condition, regardless of cost or benefit coverage, presented by your provider in a manner appropriate to your condition and ability to understand.

Be treated with dignity and respect, and to have your privacy recognized.

Keep your personal health information private as protected under federal and state laws—including oral, written and electronic information across the organization. Unauthorized people do not see or change your records. You have the right to review and get a copy of certain personal health information (there may be a fee for photocopies).

Make complaints and appeals without discrimination about the managed care organization or the care provided, and expect problems to be fairly examined and appropriately addressed.

Exercise these rights regardless of your race, physical or mental ability, ethnicity, gender, sexual orientation, creed, age, religion or your national origin, cultural or educational background, economic or health status, English proficiency, reading skills, or source of payment for your care. Expect these rights to be upheld by both Fallon Community Health Plan and its contracted providers.

Make recommendations regarding Fallon Community Health Plan's members' rights and responsibilities policies.

Member responsibilities

As a Fallon Community Health Plan member, you have the responsibility to …

Provide, to the extent possible, information that Fallon Community Health Plan, your physician or other care providers need in order to care for you.

Do your part to improve your own health condition by following the treatment plan, instruction and care that you have agreed on with your physician(s).

Understand your health problems, and participate in developing new and existing mutually agreed-upon treatment goals to the degree possible.

For answers to questions

About your rights or responsibilities as a member of Fallon Community Health Plan:

Fallon Community Health Plan
10 Chestnut Street, Worcester, Massachusetts 01608
1-866-344-4GIC
TDD/TTY: 1-877-608-7677

About your rights as a consumer:

Commonwealth of Massachusetts Department of Public Health
Office of Patient Protection
Toll-free phone: 1-800-436-7757
Fax: 1-617-624-5046
Internet: www.state.ma.us/dph/opp

About a physician (including physician profiling information):

Commonwealth of Massachusetts Board of Registration in Medicine
560 Harrison Ave., Suite G4, Boston, Massachusetts 02111
1-617-727-3086

About a hospital:

Commonwealth of Massachusetts Department of Public Health
Division of Health Care Quality
10 West Street, 5th floor, Boston, Massachusetts 02111
1-617-753-8000

About nurses, dentists, chiropractors and other nonphysician health professionals:

Commonwealth of Massachusetts
Office of Consumer Affairs/Business Regulation
Division of Registration
239 Causeway Street, 5th floor, Boston, Massachusetts 02114
1-617-727-7406

Inquiries and grievances

Whenever you have a question or need help in using our network of providers and services, we encourage you to call our Customer Service Department. If you have a question or concern regarding an adverse determination, or if you would like to file a grievance, contact our Consumer Affairs Department (see below).

An adverse determination means that FCHP has denied, reduced, modified or terminated your covered health care services for reasons of medical necessity, appropriateness of health care setting and level of care, or effectiveness.

When you make an inquiry

If you have a question or need help with an issue that is not about an adverse determination, contact FCHP Customer Service. You can reach our customer service representatives in the following ways:

Call:	1-866-344-4GIC (TDD/TTY: 1-877-608-7677) Monday through Friday 8:30 a.m. to 6:00 p.m.
E-mail:	Go to the FCHP Web site, www.fchp.org. Click on "Member Services" and then on "Contact Customer Service"
Write:	Fallon Community Health Plan Customer Service Department 10 Chestnut Street Worcester, MA 01608

In most cases, our customer service representatives will be able to answer your question or handle your request the first time you call. In some cases, however, we may need to do more research before we complete your request. In these cases, we will make every effort to provide you with a response within 3 business days. If we have not been able to provide a satisfactory response to your inquiry within this time period, we will send you a letter explaining your right to continue with the inquiry process or to have your request handled as a grievance. If you tell us that you want to have your issue handled as a grievance, we will proceed to the grievance procedure outlined below.

When you have a grievance

FCHP's consumer affairs representatives are available to assist you if you have a grievance about health plan policies, providers, services or an adverse determination made by the plan regarding your coverage. They are trained to assist you in accordance with your rights and in confidence.

Filing a grievance

You can file a grievance in any of the following ways:

Write:	Fallon Community Health Plan Consumer Affairs Department 10 Chestnut Street Worcester, MA 01608
Call:	1-866-344-4GIC (TDD/TTY: 1-877-608-7677) Monday through Friday 8:30 a.m. to 5:00 p.m.
E-mail:	grievance@fchp.org
Fax:	1-508-755-7393
Walk-in:	Fallon Community Health Plan Consumer Affairs Department 10 Chestnut Street Worcester, MA

You may file the grievance yourself, or you may have someone else (e.g., a family member, friend, physician/practitioner) do this for you. You must file your grievance within 180 calendar days from when you received the written denial. We can extend this 180-day limit if you have a good reason. If you do, state the reason when you file your grievance.

If you file a request, be sure to provide all of the following information:

- Member name
- FCHP member identification number
- Facts of the request
- Outcome that you are seeking
- Name of any FCHP representative with whom you have spoken

If you send us a written or electronic grievance, we will acknowledge your request in writing within 15 business days from the date we receive the request. If you call us or come in to our offices, we will put your grievance in writing and send the written statement to you or your authorized representative within 48 hours of the time that we talked to you. If your

grievance involves the termination of ongoing coverage or treatment, this coverage or treatment will continue until we complete our review and send you a response.

Grievance review process

In some cases we will need medical records to complete our review of your grievance. If we do, we will ask you to sign a form to authorize your provider to release the records to us. If you do not send this form within 30 calendar days, we will complete the review based on the information that we do have, without the medical records.

Your grievance will be reviewed by FCHP administrators and/or physicians who are knowledgeable about the matters at issue in the grievance. If the grievance is about an adverse determination, the reviewers will be individuals who did not participate in any of the plan's prior decisions on the issue. As part of certain types of review, we may ask you to participate in a conference. At the conference, your request will be reviewed by a committee. In some circumstances this committee might include plan physician(s) and/or administrator(s), and, in some cases, an actively practicing health care professional appropriate to the services being reviewed.

We will complete our review and send you a written response within 30 calendar days from the date that we receive your request. If we need to review medical records, the time required to receive your signed authorization will not count against the 30-day period.

If the grievance followed from an unresolved inquiry, the 30-day period will start 3 business days from the date we received the inquiry or on the day you advise us that you are not satisfied with the results of your inquiry, whichever comes first. These time limits may be waived or extended if you and the plan both agree in writing to the change.

Our response will describe the specific information considered as well as an explanation for the decision.

If the grievance is about an adverse determination, the written response will include the clinical justification for the decision, consistent with generally accepted principles of professional medical practice; the information on which the decision was based—pertinent information on your condition, alternative treatment options as appropriate, clinical guidelines or criteria used to make the decision; and your right to request external review.

Opportunity for reconsideration

You may ask for a reconsideration of a final adverse determination if any relevant information was received too late to review within the 30-day limit or is expected to become available within a reasonable time period after you receive our written response. In this case, we would agree in writing to a new time period for review. This would not be longer than 30 days from the date we agree to the reconsideration.

Expedited review

You can request an expedited (fast) review either orally or in writing. You can file for an expedited review in any of the following circumstances:

- You are an inpatient in the hospital and your grievance concerns termination of coverage for your hospital stay.
- Your physician certifies that, unless action is taken within 48 hours, you could sustain immediate and severe harm.
- You believe that not receiving the services which have been denied could pose a threat to your health, life, or ability to regain maximum function.
- You have an illness in which your life expectancy is expected to be less than six months.

In certain cases, we may automatically reverse our denial of coverage for services or durable medical equipment pending the outcome of our review. To obtain this reversal, your physician must certify in writing that the service or durable medical equipment is medically necessary, that a denial of coverage for the services would create a substantial risk of serious harm to you, and that this risk is so immediate that you cannot wait for the outcome of the normal grievance process. The reversal will be made within 48 hours of our receipt of the request. Reversal can be earlier than the 48 hours for durable medical equipment, at the option of the treating physician. In this case the physician must certify to the specific, immediate and severe harm that would result to you in the absence of action within the 48-hour period.

If you are an inpatient at the time you file your grievance, we will respond to your grievance before you are discharged from the hospital. In all other expedited reviews, we will send you a written response within 72 hours of our receipt of the request.

Our response will describe the specific information considered as well as an explanation for the decision.

If the grievance is about an adverse determination, the written response will include the clinical justification for the decision, consistent with generally accepted principles of professional medical practice; the information on which the decision was based; pertinent information on your condition; alternative treatment options as appropriate; clinical guidelines or criteria used to make the decision and your right to request external review.

If you have a terminal illness, we will respond to you within 5 business days from our receipt of your request. If you have a terminal illness, and if our review of your expedited review results in denial of coverage, you may request a conference. We will schedule the conference within 10 business days from the date on which we receive your request; or within 5 business days if your physician determines, after consultation with a plan medical director, that based on standard medical practice, the effectiveness of the proposed treatment, services or supplies or any alternative treatment, services or supplies would be materially reduced if not provided at the earliest possible date. You may attend the conference, but your attendance is not required.

Failure to meet time limits

If we do not complete a review in the time limits specified above, the decision will automatically be in favor of the member. Time limits include any extensions made by mutual written agreement between you or your authorized representative and the plan.

External review

If your grievance involved an adverse determination, and you are not satisfied with our final decision, you have the right to file the case with the Department of Public Health Office of Patient Protection for review with an external review agency. You must make this request in writing within 45 business days from receiving the written notice of the final adverse determination. If the subject matter of the external review involves the termination of ongoing services, you may apply to the external review panel to seek the continuation of coverage or treatment. We will enclose the external review request form with the final adverse determination letter.

Expedited external review

In some cases, you may request an expedited external review. To do so, you must submit a written certification from your physician stating that there would be a serious and immediate threat to your health if there was a delay in providing or continuing to provide the health care services that are the subject of the final adverse determination.

You may obtain the forms you need to file for an external review by calling the Department of Public Health Office of Patient Protection at 1-800-436-7757 or by accessing their Web site at www.state.ma.us/dph/opp.

Your request should:

- Be on the standardized form from the Department of Public Health Office of Patient Protection
- Include your signature or your authorized representative's signature
- Include a copy of the written final adverse determination made by the plan
- Include the required $25 fee payable to the Department of Public Health. The fee may be waived by the Office of Patient Protection if it determines that the payment of the fee would result in an extreme financial hardship to the member.

We will consider any decision made by the external review panel to be binding on the plan.

Massachusetts Office of Patient Protection

The Office of Patient Protection (OPP) was established within the Massachusetts Department of Public Health with the authority to administer and enforce the standards and procedures established under (Massachusetts) Chapter 141 of the Acts of 2000. The OPP will make information on managed care plans accessible to consumers, assist consumers with questions and concerns related to managed care, monitor quality-related plan information relating to managed care practices and regulate the external review process. FCHP and other Massachusetts plans provide the following information to OPP by May 15th of each year:

- Member satisfaction rates and quality of care rates for the plan
- The number of physicians who voluntarily or involuntarily left the plan network last year
- The percentage of plan premium revenue that went towards health care compared to the amount that went towards plan administrative expenses
- The number of grievances filed in the last year by plan members, and the outcome of those grievances. This will include the total number of grievances filed, grievances that were approved internally, grievances withdrawn before resolution, and external reviews filed with OPP.

The Office of Patient Protection can be reached by phone at 1-800-436-7757 or 1-617-284-8315; by fax at 1-617-624-5046; or via their Web site at www.state.ma.us/dph/opp.

This section contains:

The claims process

Claims, reimbursements and refunds

You should never receive a bill for any covered services from a network provider. Your network provider has an agreement with the plan to send claims directly to us. If you do receive a bill for covered services, you can write your FCHP coverage information on the back of the bill and return it to the provider's office with a request to bill us directly.

Urgent/ER bills

If you receive a bill for urgent or emergency care from a non-network provider, send it to us within 6 months of the date of service. You may submit the bill yourself, or the provider may submit it directly. All bills should include a description of the services, the dates of services and the charge for each service.

Send bills to:

Fallon Community Health Plan
Claims Department
P.O. Box 15121
Worcester, Massachusetts 01615-0121

We will pay for the reasonable cost of services minus the appropriate copayment. Payment will not be more than the reasonable or customary charge in the community where the services were provided. If the provider is not contracted with FCHP and bills you for more than this reasonable or customary charge, you are responsible for the balance. We will make payment directly to the provider unless you prove that you have already paid the bill.

Care in foreign countries

You may submit claims for urgent or emergency services in a foreign country if the services are not provided free of charge by that country. The bills must be itemized and in (or translated into) English. Payment will be made to you, and you must pay the provider.

Recovering money owed

We have the right to recover any money you owe to us, a health plan physician, or a health plan facility, or any other person or facility providing services to you on behalf of the plan. We will do so by offsetting the amount you owe us with any reimbursement payments we may owe you. This will satisfy our obligation to pay for services you receive.

Claims questions/refunds

If you have a question regarding a claim, you should contact Claims Customer Service. If you feel you are entitled to an adjustment or refund due to discrepancies in the effective date of your coverage or your contract type, send a letter to:

Fallon Community Health Plan
Customer Service Department
10 Chestnut Street
Worcester, Massachusetts 01608

If you have a plan sponsor, you should notify the plan sponsor instead. Adjustments or refunds will be approved in accordance with our underwriting guidelines. We will not approve an adjustment or refund if it is for something that took place more than one year before we receive your letter, or if it is for an amount less than $5.

Coordination of benefits

Coordination of benefits (COB) takes place when more than one health insurance plan covers a service. This includes plans that provide benefits for hospital, medical, dental or other health care expenses.

Under COB, one plan pays full benefits as the primary carrier. The other (the secondary carrier) pays the balance of covered charges. The primary and secondary carriers are determined by the standard rules that are used by all insurance companies.

We have the right to exchange benefit information with any other group plan, insurer, organization or person to determine benefits payable using COB. We have the right to obtain reimbursement from you or another party for services provided to you. You must provide information and assistance and sign the necessary documents to help us receive payment. You must not do anything to

limit this repayment. If payments have been made under any other plan that should have been made under this plan, we have the right to reimburse the plan to the extent necessary to satisfy the intent of COB. If we pay benefits in good faith to a plan, we will not have to pay such benefits again. We also have the right to recover any overpayment made because of coverage under another plan.

We will not duplicate payment for any service. We will not make payment for more than the full benefit available under this contract. If we provide or arrange services when another carrier is primary, we have the right to recover any overpayment from the primary carrier or other appropriate party. If we do not receive the necessary documentation from you, we may deny your claim.

In order to obtain all the benefits available, you must file claims under each plan.

Subrogation

Subrogation (a process of substituting one creditor for another) applies if you have a legal right to payment from an individual or organization because another party was responsible for your illness or injury.

We may use your subrogation right, with or without your consent, to recover from the responsible party or that party's insurer the cost of services provided or expenses incurred by us that are related to your illness or injury. We will notify you of the right to reimbursement prior to settlement or judgment. If you are reimbursed by the responsible party, we have the right to recover from you the cost of services provided or expenses incurred. Our right to repayment comes first, even if you are not paid for all your claims against the other party, or if the payment you receive is described as payment for other than health care expenses. Any recovery from your personal injury protection coverage under a Massachusetts automobile policy shall be limited in accordance with the law. If we do not receive the necessary documentation from you, we may deny your claim.

Workers' compensation

The plan does not cover any services or supplies that are covered by workers' compensation insurance or a similar program. If you are eligible for workers' compensation or a similar employer's liability coverage, we may request information from you before processing claims. If we do not receive the necessary documentation from you, we may deny your claim.

Medicare

If you are entitled to Medicare, Medicare is generally considered to be your primary health insurance, even if you also have health coverage provided by the plan. However, there are some circumstances in which the plan might be primary over Medicare. Your age, work status and (if you are eligible for Medicare due to disability) the presence of specific disabling medical conditions may affect which coverage is considered to be your primary insurance.

If you are entitled to Medicare, and Medicare is your primary carrier, we have a legal right to obtain reimbursement for services provided to you by us or a provider you see on a referral, if the services are covered by Medicare.

This section contains:

How your coverage works

Eligibility

You are eligible to enroll in the plan as a subscriber as long as you live or work in the health plan service area and you meet underwriting guidelines.

Usually, you can make changes to your insurance coverage only once during a year—on your group's "anniversary date." During a designated "open enrollment" period prior to the anniversary date, any changes that you make become effective on the anniversary date. If you have any questions about your group's enrollment period or anniversary date, please contact your employer or plan sponsor.

New subscribers may enroll in this plan during open enrollment, or within 31 days of the date they are first eligible. Employee eligibility will begin on the first day of the month following 60 days of employment or two calendar months, whichever is less. New subscribers may also be eligible to enroll at a later date under the following circumstances:

- You declined this coverage when first eligible because you or your eligible dependent were covered under another group health plan or another health insurance coverage, but the other coverage has ended. You and your dependent may enroll in this plan within 31 days of your termination of coverage under the other health plan.
- You declined this coverage when first eligible, but have since acquired a dependent through marriage, birth or adoption. You or your dependent may enroll within 31 days of the date of the marriage, birth or adoption (including any probationary period).

Except for the above circumstances, employees who choose not to join the plan when first eligible must wait until the next open enrollment period to join.

Premium charges

The Commission will pay the premium charge for you. We will send the bill to the Commission. Your coverage may be terminated if the Commission fails to pay, even if they have charged you all or part of the premium charge (for example, by withholding it from your pay). Please see the attached "Addendum, Premium Charge" for the amount that the Commission pays to FCHP for your premium charge.

Failure to pay premiums

If we or our agent do not receive the premium charge by the time it is due, your coverage may be suspended and your contract terminated as described on page 61. There is a 31-day grace period, after which the contract will be suspended. Group contracts will be cancelled on the 56th day after the due date if we have not received payment.

Types of coverage

The subscriber may choose between individual coverage and family coverage.

If a subscriber chooses individual coverage, the contract covers only the subscriber.

If a subscriber chooses family coverage, the contract covers:

- The subscriber
- The subscriber's legal spouse
- Dependent children until they reach age 19 or marry, whichever comes first
- Dependent children who are enrolled as full-time students until they reach age 24 or marry, whichever comes first
- Dependent children who, by age 19, are mentally or physically incapable of earning a living. These children, while dependents under the family contract, must get approval from the Commission to enroll or continue coverage under the family contract after the end of the month in which they turn 19.
- A former spouse, unless the divorce judgment specifies otherwise, or the subscriber or the former spouse remarries (see "Divorce" on page 51).

"Dependent children" includes your or your spouse's children by birth or adoption; children who are under your or your spouse's legal guardianship; and children who are dependent upon you for support, live in your household, are under age 19, and have a parent-child relationship with you (these children must get approval from the Commission to enroll under the family contract). Adopted children are included from the date of placement in the home or, in the case of a foster child, from the date of the filing of the petition to adopt. If your dependent child has a child, that child is included as a family member as long as your dependent child remains eligible.

Adding dependents

The subscriber may always change to family coverage, or add additional dependents to family coverage, during open enrollment. Changes made during the open enrollment period will be effective on the group's anniversary date.

In addition, the subscriber may change to family coverage or add dependents to family coverage at the time of the following qualifying events:

- The subscriber marries. The subscriber may change to family coverage, or add any additional dependents to family coverage at this time.
- Birth or adoption of a child. The subscriber may change to family coverage, or add any additional dependents to family coverage at this time. Coverage will be retroactive to the newborn's date of birth (see below).
- Loss of other health insurance coverage by a spouse and/or child(ren) who are not currently covered under the subscriber's contract. The subscriber may add only those dependents who have lost their other coverage. If the previous coverage was not through FCHP, we will require notification from the prior insurance company.
- A spouse and/or child(ren) who formerly lived outside FCHP's service area move into the service area. The subscriber may add only those dependents who have just moved into the service area.
- An unmarried dependent child under age 24, who is not currently covered under the subscriber's contract, enrolls as a full-time student at an accredited institution. The subscriber may add only the dependent who has enrolled as a full-time student. See page 50 for more information about coverage for full-time students.
- The subscriber is ordered by a court to provide coverage for a spouse, former spouse or child(ren). See page 51 for more information about coverage of former spouses in the event of divorce.

Hospital charges for the routine care of a newborn following delivery are covered under either individual or family coverage. Any other services for your newborn children or other new dependents are covered only if the dependent is enrolled under your family coverage.

Changing your coverage

A change made at the time of a qualifying event will be effective on the date of the qualifying event if the premium is paid when due. You must notify the Commission of the change within 60 days of the event. If you do not request the change within the 60-day period, you may not make a change until your next anniversary date.

Age limits for dependent children

An unmarried dependent child is eligible for coverage until the child's 19th birthday. Coverage under the family contract will be terminated as of midnight of the day before the dependent's 19th birthday. If a dependent child marries before age 19, the child is covered only until the date of marriage. Unmarried dependent children over age 19 may be eligible to remain under the family coverage indefinitely if they are handicapped, or until age 24 if they are full-time students; see the following sections for more information.

A dependent child who is no longer eligible due to age or marriage also may be eligible for continuation of coverage or conversion to an individual guarantee-issue plan (see pages 66 to 71). Whenever a dependent child's coverage under the family coverage ends, the coverage for any offspring of that dependent child also ends.

Handicapped dependents

If a dependent child is mentally or physically handicapped when he or she reaches age 19, and is not capable of earning his or her own living, the child can continue to be covered under the family contract. The subscriber or the plan sponsor must apply within 30 days of the dependent child's 19th birthday. The subscriber or plan sponsor can also apply for coverage for a dependent over age 19 who was previously covered as a full-time student, within 30 days of the dependent reaching age 24 or ceasing to be a full-time student. The plan determines eligibility for handicapped children. The subscriber must supply us with any medical or other information that may be needed to determine if the child is eligible to continue coverage under the family coverage.

Student dependents

An unmarried dependent child enrolled as a full-time student at an accredited institution may remain on the family coverage until his or her 24th birthday. If the student dependent marries or graduates (or otherwise ceases to be a full-time student) before reaching age 24, he or she loses eligibility. Any offspring of the dependent child also lose eligibility at that time.

Coverage for graduating students ends at the end of the month in which the student completes classes. For example, if the student finishes classes in the fall semester (ending in December), coverage would end on December 31, even if the student does not actually graduate until the following May. If a dependent withdraws from school or drops to less than a full-time course load, his or her coverage ends at the end of the month in which he or she was last a full-time student.

Certify full-time status

When a dependent reaches age 19, the Commission will send a letter and certification form to the subscriber's home address to determine the dependent's status. If the dependent is a full-time student at an accredited institution, the subscriber should forward this form to the school registrar's office for verification and return it to the Commission within 60 days. We must have the school registrar's verification of active full-time status to approve continued coverage. The Commission will notify us as to the student's eligibility. A student who takes a number of courses at different schools for a total of a full-time course load is ineligible because each school would verify the student as part-time. The subscriber is responsible for notifying us of a student's graduation or of other changes in student status.

We will send a recertification form at the beginning of each academic semester. If you return the form stating that the dependent is no longer a full-time student, student dependent coverage will end on the end of the month in which he or she was last a full-time student. If the form is not returned within 60 days, we will assume that the dependent is not presently a full-time student and coverage will end. In all of these cases, we will send a letter of termination of coverage to the subscriber.

Continuing coverage for former dependents

A dependent child who is no longer eligible for coverage may be eligible for continuation of coverage or conversion to an individual guaranteed issue policy (see pages 66 to 71).

Surviving dependents

In the case of the death of an employee or retiree, the surviving spouse may continue coverage until remarriage. The surviving spouse must apply to the Commission for this service within 60 days of the date of death.

In the case of death of a single or divorced employee or retiree, or of the surviving spouse of a deceased employee or retiree, dependent children may continue coverage under this program until age 19 or until they become eligible for other group health coverage, whichever is earlier. Applications for continued coverage must be made within 60 days of the death of the insured parent.

Divorce

In the event of divorce, the subscriber's former spouse may remain under the family coverage. Coverage may continue, with no additional premium due, unless: (1) the divorce decree does not require (or no longer requires) the subscriber to maintain health insurance coverage for the former spouse, or (2) either the subscriber or the former spouse remarries.

If the subscriber remarries and wishes to add his or her new spouse to the family coverage, the former spouse remains eligible for coverage under the subscriber's group. However, the former spouse must move from family coverage to individual coverage and additional premium will be required; the former spouse only remains eligible under the group if the divorce decree provides for such coverage. If the former spouse remarries, the former spouse's eligibility ends.

Notice of cancellation of coverage of a former spouse will be mailed to the former spouse at his or her last known address, along with notice of any applicable right to reinstate coverage retroactively to the date of cancellation. The former spouse may be eligible for continuation of coverage or conversion to an individual guaranteed issue policy (see pages 66 to 71).

This section contains:

Fallon Community Health Plan contract arrangements

Changes in your coverage

We may change part of your contract. If we do, the change will apply to all contracts of this type, not just your contract. We will send you or your plan sponsor notice of any material modifications to your coverage within 60 days of the change. The contract will be changed whether or not you receive the notice. The notice will indicate effective date of the change. We will send the notice to the sponsor. It will be the plan sponsor's responsibility to notify you.

FCHP contracting arrangements

The plan contracts with individual physicians, medical groups and hospitals to provide care to members. FCHP negotiates with providers to agree upon a contracted payment rate. The providers then accept that payment for their services. When you obtain a covered service, the only payment that a provider will collect from you for a covered service is the copayment amount shown in this *Member Handbook*, or in any applicable riders.

FCHP pays its providers using various payment methods including capitation and per diem. Capitation means paying a fixed dollar amount per month for each member assigned to the provider. Per diem means paying a fixed dollar amount per day for all services rendered.

When your provider no longer has a contract with us

We cannot guarantee that any one physician, hospital or other provider will be available and/or remain under contract with us. We reserve the right at any time to end our contract with your PCP or with any other network provider who may be furnishing you with treatment. If this occurs, we will generally no longer pay for services provided to you by that provider, except in the circumstances listed below.

If the provider whose contract we are ending is your PCP, we will notify you in writing at least 30 days prior to the date of the end of his or her contract, except where the contract has been ended for reasons involving fraud, patient safety or quality of care. If our contract with your PCP ends,

you will be required to select a new PCP. We will also notify you if you are receiving regular care from a specialist, and that specialist will no longer be under contract with us.

We will continue to pay for services from your provider after our contract with the provider ends, in the following circumstances only:

- If our contract with your PCP ends, you may continue to receive treatment from that provider for 30 days beyond the end of the contract.
- If you are in the second or third trimester of pregnancy when our contract with a provider from whom you are receiving pregnancy-related treatment ends, you may continue to receive treatment from that provider through your postpartum period.
- If you are terminally ill and our contract with a provider from whom you are receiving treatment related to that illness ends, you may continue to receive treatment from that provider.

In all cases, the provider must agree to accept reimbursement for services at the rates in effect when our contract with the provider ended, and to adhere to our quality assurance standards and other policies and procedures such as referrals and prior authorization. You will be eligible for benefits as if the provider had remained under contract with us.

If your provider is no longer under contract with us, call Customer Service for assistance in choosing a new PCP or to request a Provider Directory. You also can get provider information and choose a new PCP on our Web site at www.fchp.org.

Continuation of services with a non-network provider

Once you become a plan member, we will generally only pay for services that you receive from network providers. However, there are some circumstances in which we will temporarily pay for services that you receive from a non-network provider, if you had been receiving care from that provider prior to becoming a member:

- If your prior PCP is not a participating provider in any health insurance plan that your plan sponsor offers, we will pay for services from that provider for 30 days from your effective date.
- If you are receiving an ongoing course of treatment from a provider who is not a participating provider in any health insurance plan that your plan sponsor offers, we will pay for services from that provider for 30 days from your effective date.

- If you are in the second or third trimester of pregnancy, and you are receiving services related to your pregnancy from a provider who is not a participating provider in any health insurance plan that your plan sponsor offers, we will pay for services from that provider through your postpartum period.
- If you are terminally ill, and you are receiving ongoing treatment from a provider who is not a participating provider in any health insurance plan that your plan sponsor offers, we will pay for your services from that provider until your death.

In all cases, the provider must agree to accept reimbursement for services at our rates, and to adhere to our quality assurance standards and other policies and procedures such as obtaining appropriate referrals and prior authorizations. You will be eligible for benefits as if the provider was under contract with us.

Responsibility for the acts of providers

The arrangement between the plan, network providers and the plan facilities is that of independent contractors. They are not our agents. We are not liable for injuries or damages resulting from acts or omissions by them or by any other institution or person providing services to you. We will not interfere with the ordinary relationship between providers and their patients except in circumstances in which a provider does not comply with health plan policies.

If you are admitted to a hospital or other facility as an inpatient, or if you are an outpatient, you will be subject to all of that facility's rules. This includes rules on admission, discharge and the availability of services.

If a provider recommends specific treatment, this does not necessarily make that treatment a covered benefit. Since network providers are freely able to recommend treatment options without restraint from the health plan, a referral in and of itself does not guarantee that a referral or recommended treatment is a covered benefit or that the accepting provider is contracted with the plan, and does not obligate the plan to pay for the service. Services or supplies that are not described as covered in this *Member Handbook*, or that did not receive any necessary authorization from the plan, are not covered benefits.

Circumstances beyond our control

Under extraordinary circumstances that are beyond our control, we may have to delay your services, or we may be unable to provide them at all. We will not be liable for failing to provide, or for a delay in providing, services in the cases described below. We will, however, make a good faith effort to provide or arrange for services in these situations, limited by available facilities and personnel:

- In the case of major natural disasters or epidemics
- In the case of a war, riot or civil insurrection

This section contains:

Leaving Fallon Community Health Plan

Ineligibility for you or a dependent

A subscriber's group membership may end because he or she:

- Is laid off
- Leaves a job
- Loses coverage due to a reduction in work hours
- No longer lives in the plan service area

A dependent's membership may end because of:

- Age, marriage, graduation or a change in student status
- Divorce
- Loss of the subscriber's eligibility
- The subscriber's death

Dependent coverage under the plan will cease on the last day of the month when a family member no longer qualifies as a dependent under the rules and regulations of the Commission (e.g., attainment of age 19 of a minor dependent, marriage of a minor dependent, termination of full-time student status, loss of eligibility due to divorce).

If a subscriber's group coverage ends, the subscriber and any dependents may have a right to choose continued group coverage to the extent required by state and federal law. Contact your plan sponsor for information on eligibility and continued enrollment. (For more information about continuation of coverage once you are no longer eligible through your group, or conversion to an individual guaranteed issue contract, see pages 66 to 71.)

Cancellation by FCHP

You do not have to worry that FCHP will cancel your contract because you are using services or because you will need more services in the future. We will cancel contracts only for the following reasons:

- You no longer live or work in the plan service area. Notify the Commission within 60 days of the date you move.
- You made some misrepresentation or you conspired with another party to defraud the health plan. An example is an incorrect or incomplete statement on your application form that indicated that you were eligible for coverage when you were not. In such a case, cancellation will be as of your effective date or other date we determine appropriate. We will refund the premium charge you have paid if applicable. Any payments made for claims under this contract will be subtracted from the refund. If we have paid more for claims under this contract than you have paid in premium charges, we have the right to collect the excess from you. In any case of misrepresentation, the health plan may deny enrollment to you in the future.
- Your premium charge is not paid within the grace period appropriate for your health plan. (See page 47 for information about grace periods and nonpayment of premium.) We will notify you of the effective date of the cancellation, in accordance with Massachusetts insurance regulations.
- You commit an act of physical or verbal abuse that poses a threat to a network provider, a plan employee or another plan member. In such an instance, we must determine that the act of abuse was not related to your physical or mental condition.
- The Commission cancels its group service agreement with FCHP. In the event that your group coverage is canceled because the group fails to pay the premium charge to us, you may apply for short-term (60-day) conversion coverage. To apply for this coverage, send us a written request within 60 days of the day you receive our notice of the group's cancellation. The 60-day conversion coverage will be available at the same cost and coverage level as you previously had under your group coverage. At the end of your 60-day conversion coverage, if you would like to remain a FCHP member, you can join our Independent Plan. (See pages 66 to 71.)

In accordance with state law, FCHP will not require genetic testing or the submission of genetic information as a condition of initial or continued enrollment. We will not discriminate or make any distinction among members based on any genetic test or information.

Involuntary cancellation rate

For the calendar year 2003, FCHP's involuntary cancellation or disenrollment rate was 0%. The involuntary disenrollment rate includes any members disenrolled by the plan due to misrepresentation or fraud on the part of the member or commission of acts of verbal or physical abuse. For calendar year 2003, FCHP's voluntary disenrollment rate was 2%.

Disenrollment by the subscriber

To cancel your contract, the subscriber or the Commission must give us notice in writing 30 days prior to cancellation. If the premium charge is paid for a period beyond the cancellation date, we will refund the premium charge for that period. If the subscriber or the Commission cancels the contract, we will not provide benefits for services, supplies or medication received after the cancellation date.

Eligibility for Medicare

If you are a member age 65 or older, your eligibility may change in one of the ways shown below.

- If you are employed after age 65, you and your dependents may remain covered under this contract as long as you are an active employee.
- If you become eligible for Medicare and you are no longer employed, you are no longer eligible for coverage under this contract. You may be eligible for enrollment in Fallon Senior Plan™, our Medicare + Choice product, either through the Commission or directly with Fallon. To enroll, you must have both Medicare Part A and Part B, live in the Fallon Senior Plan service area and pay the premium charge when applicable. Please contact our Customer Service Department for more information.
- If you are not eligible for Medicare upon reaching age 65, you may continue to be covered under this contract.

Once you have retired and become eligible for Medicare, you may elect to continue with the plan through the Fallon Senior Plan.™ You may join the Fallon Senior Plan™ even if enrollment is closed to the general public. To enroll, you must have both Medicare Part A and Part B and live in the Senior Plan service area. If you have a spouse and/or dependents who were covered under your group membership before you turned 65, they may continue coverage in that group for as long as they are eligible.

Changing to other health insurance

As long as the Commission agrees, you may change your coverage to any other health benefits plan offered where you work. You may do this within 30 days of any of the following:

- The anniversary date of your group. There will generally be an open enrollment period preceding your group's anniversary date, during which you can arrange for changes that will be effective on the anniversary date. There also may be a special enrollment period determined by FCHP and your group.
- The day you move to a place outside the plan service area
- The date you become eligible to enroll in another federally qualified health maintenance organization within the plan service area for which you were not formerly eligible because of where you live
- The date we are no longer a part of the health benefits plan offered where you work
- The date the plan stops operation

Please note: Nothing in this section changes the application of the coordination of benefits between the plan and any other health benefits plan.

Obtaining a certificate of creditable coverage

If you cancel your enrollment with FCHP, the GIC will send you a Certificate of Creditable Coverage, free of charge. This certificate gives you proof of continued coverage that can help you obtain other coverage without a pre-existing condition clause. You may request additional copies of the certificate by calling the GIC's Public Information Unit.

This section contains:

Continuation Coverage

Group health continuation coverage under COBRA

You are receiving this notice because you are covered under the Group Insurance Commission's (GIC's) health benefits program. This notice contains important information about your right to continue group health coverage at COBRA group rates if your group coverage otherwise would end due to certain life events. Please read it carefully.

What is COBRA coverage?

COBRA is a federal law under which certain former employees, retirees, spouses, former spouses and dependent children have the right to temporarily continue their existing group health coverage at group rates when group coverage otherwise would end due to certain life events, called "Qualifying Events." If you elect COBRA coverage, you are entitled to the same coverage being provided under the GIC's plan to similarly situated employees or dependents. The GIC administers COBRA coverage.

This notice explains your COBRA rights and what you need to do to protect your right to receive it. If you have questions about COBRA coverage, contact the GIC's Public Information Unit at (617) 727-2301, ext. 801 or write to the Unit at P.O. Box 8747, Boston, MA 02114. You may also contact the U.S. Department of Labor's Employee Benefits Security Administration's website at www.dol.gov/ebsa.

Who is eligible for COBRA coverage?

Each individual entitled to COBRA (known as a "Qualified Beneficiary") has an independent right to elect the coverage, regardless of whether or not other eligible family members elect it. Qualified Beneficiaries may elect to continue their group coverage that otherwise would end due to the following life events:

If you are an employee of the Commonwealth of Massachusetts covered by the GIC's health benefits program, you have the right to choose COBRA coverage if:

- You lose your group health coverage because your hours of employment are reduced; or
- Your employment ends for reasons other than gross misconduct.

If you are the spouse of an employee covered by the GIC's health benefits program, you have the right to choose COBRA coverage for yourself if you lose GIC health coverage for any of the following reasons (known as "qualifying events"):

- Your spouse dies;
- Your spouse's employment with the Commonwealth ends (for reasons other than gross misconduct) or his/her hours of employment are reduced; or
- You and your spouse divorce or legally separate.

If you have dependent children who are covered by the GIC's health benefits program, each child has the right to elect COBRA coverage if he or she loses GIC health coverage for any of the following reasons (known as "qualifying events"):

- The employee-parent dies;
- The employee-parent's employment is terminated (for reasons other than gross misconduct) or the parent's hours of employment are reduced;
- The parents divorce or legally separate; or
- The dependent ceases to be a dependent child (e.g., is over age 19 and is not a full time student, or ceases to be a full-time student).

How long does COBRA coverage last?

By law, COBRA coverage must begin on the day immediately after your group health coverage otherwise would end. If your group coverage ends due to employment termination or reduction in employment hours, COBRA coverage may last for up to 18 months. If it ends due to any other qualifying events listed above, you may maintain COBRA coverage for up to 36 months.

If you have COBRA coverage due to employment termination or reduction in hours, your family members' COBRA coverage may be extended beyond the initial 18-month period up to a total of 36 months (as measured from the initial qualifying event) if a second qualifying event—the insured's death or divorce—occurs during the 18 months of COBRA coverage. You must notify the GIC in writing within 60 days of the second qualifying event and before the 18-month COBRA period ends in order to extend the coverage. Your COBRA coverage may be extended to a total of 29 months (as measured from the initial qualifying event) if any qualified beneficiary in your family receiving COBRA coverage is disabled during

the first 60 days of your 18-month COBRA coverage. You must provide the GIC with a copy of the Social Security Administration's disability determination within 60 days after you receive it and before your initial 18 month COBRA period ends in order to extend the coverage.

COBRA coverage will end before the maximum coverage period ends if any of the following occurs:

- The COBRA cost is not paid in full when due (see section on paying for COBRA);
- You or another qualified beneficiary become covered under another group health plan that does not impose any pre-existing condition exclusion for the qualified beneficiary's pre-existing covered condition covered by COBRA benefits;
- You are no longer disabled as determined by the Social Security Administration (if your COBRA coverage was extended to 29 months due to disability);
- The Commonwealth of Massachusetts no longer provides group health coverage to any of its employees; or
- Any reason for which the GIC terminates a non-COBRA enrollee's coverage (such as fraud).

The GIC will notify you in writing if your COBRA coverage is to be terminated before the maximum coverage period ends. The GIC reserves the right to terminate your COBRA coverage retroactively if you are subsequently found to have been ineligible for coverage.

How and when do I elect COBRA coverage?

Qualified beneficiaries must elect COBRA coverage within 60 days of the date that their group coverage otherwise would end or within 60 days of receiving a COBRA notice, whichever is later. A qualified beneficiary may change a prior rejection of COBRA election any time until that date. If you do not elect COBRA coverage within the 60-day election period, you will lose all rights to COBRA coverage.

There are several considerations when deciding whether to elect COBRA coverage. COBRA coverage can help you avoid incurring a coverage gap of more than 63 days, which under Federal law can cause you to lose your right to be exempt from pre-existing condition exclusions when you elect subsequent health plan coverage. If you have COBRA coverage for the maximum period available to you, it provides you the right to purchase individual health insurance policies

that do not impose such pre-existing condition exclusions. You also have special enrollment rights under federal law, including the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a spouse's plan) within 30 days after your COBRA coverage ends.

How much does COBRA coverage cost?

Under COBRA, you must pay 102% of the applicable cost of your COBRA coverage. If your COBRA coverage is extended to 29 months due to disability, your cost will increase to 150% of the applicable full cost rate for the additional 11 months of coverage. COBRA costs will change periodically.

How and when do I pay for COBRA coverage?

If you elect COBRA coverage, you must make your first payment for COBRA coverage within 45 days after the date you elect it. If you do not make your first payment for COBRA coverage within the 45-day period, you will lose all COBRA coverage rights under the plan.

Your first payment must cover the cost of COBRA coverage from the time your coverage would have ended up to the time you make the first payment. Services cannot be covered until the GIC receives and processes this first payment, and you are responsible for making sure that the amount of your first payment is enough to cover this entire period. After you make your first payment, you will be required to pay for COBRA coverage for each subsequent month of coverage. These periodic payments are due usually around the 15th of each month. The GIC will send monthly bills, specifying the due date for payment and the address to which payment is to be sent for COBRA coverage, but you are responsible for paying for the coverage even if you do not receive a monthly statement. Payments should be sent to the GIC's address on the bill.

After the first payment, you will have a 30-day grace period beyond the due date on each monthly bill in which to make your monthly payment. Your COBRA coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. If you fail to make a periodic payment before the end of the grace period for that payment, you will lose all rights to COBRA coverage.

Can I elect other health coverage besides COBRA?

Yes. You have the right to enroll, within 31 days after coverage ends, in an individual health insurance "conversion" policy with your current health plan

without providing proof of insurability. The benefits provided under such a policy might not be identical to those provided through COBRA. You may exercise this right in lieu of electing COBRA coverage, or you may exercise this right after you have received the maximum COBRA coverage available to you.

Your COBRA coverage responsibilities

- You must inform the GIC of any address changes to preserve your COBRA rights;
- You must elect COBRA within 60 days from the date you receive a COBRA notice or would lose group coverage due to one of the qualifying events described above. If you do not elect COBRA coverage within the 60-day limit, your group health benefits coverage will end and you will lose all rights to COBRA coverage.
- You must make the first payment for COBRA coverage within 45 days after you elect COBRA. If you do not make your first payment for the entire COBRA cost due within that 45-day period, you will lose all COBRA coverage rights.
- You must pay the subsequent monthly cost for COBRA coverage in full by the end of the 30-day grace period after the due date on the bill. If you do not make payment in full by the end of the 30-day grace period after the due date on the bill, your COBRA coverage will end.
- You must inform the GIC within 60 days of the later of either (1) the date of any of the following, or (2) the date on which coverage would be lost because of any of the following events:
- The employee's job terminates or his/her hours are reduced;
- The employee or former employee dies;
- The employee divorces or legally separates;
- The employee or employee's former spouse remarries;
- A covered child ceases to be a dependent;
- The Social Security Administration determines that the employee or a covered family member is disabled; or
- The Social Security Administration determines that the employee or a covered family member is no longer disabled.

If you do not inform the GIC of these events within the time period specified above, you will lose all rights to COBRA coverage. To notify the GIC of any of the above events within the 60 days for providing notice, send a letter to the Public Information Unit at Group Insurance Commission, P. O. Box 8747, Boston, MA 02114-8747.

Family and Medical Leave Act

Under the Family and Medical Leave Act, you may be able to take up to 12 weeks of unpaid leave from your employment due to certain family or medical circumstances. Contact your plan sponsor to find out if you qualify. If you do, you may continue group health coverage during your leave, but you must continue to pay the portion of the premium that you would pay if you were actively working. Your coverage will be subject to suspension or cancellation if you fail to pay your premium on time (see page 70). If you take a leave and group coverage is cancelled for any reason during your leave, you may resume coverage when you return to work without waiting for an open enrollment period.

Changing to FCHP Independent Care

If your eligibility for health insurance coverage through the GIC ends and you are not eligible for either Medicare or Medicaid, you are eligible to join a guaranteed issue plan. FCHP's Independent Care is a guaranteed issue plan.

To join FCHP Independent Care, notify FCHP within 63 days of the date your coverage ends to minimize any potential benefit waiting period. Let FCHP know that you want to change to Independent Care and pay the premium charge that will be due for your new membership. Your new membership will be effective on the date your coverage ends.

You may also be eligible to convert to FCHP Independent Care if you lose your eligibility for group coverage as a dependent. Notify FCHP within 63 days of your loss of group coverage to minimize any potential benefit waiting period. You may not convert to FCHP Independent Care if your group coverage ended because of fraud on your part.

This section contains:

Your costs for covered services

Description of benefits

Your costs for covered services

Copayments

Please refer to the addendum enclosed in this *Member Handbook* for your specific copayments and the maximum amount of copayments you are responsible for in a calendar year.

Coinsurance

Coinsurance is your share of the allowed charge for certain covered benefits, usually expressed as a percentage. For example, if your coinsurance amount is 20%, you pay 20% of the allowed charges for the purchase or rental of covered durable medical equipment you receive, and the plan pays the remaining 80%.

As a member of this plan, you are responsible for coinsurance for the following:

- Durable medical equipment
  - Plan pays: 80% of the purchase price or rental cost;
  - You pay: 20% of the purchase price or rental cost.

- Hearing aids:
  - Plan pays: 100% of the first $500 of the purchase price; and 80% of the next $1,500 of the purchase price;
  - You pay: 20% of the purchase price between $501 and $2,000, plus all additional costs

Description of benefits

The following section contains a description of your covered services as a member of FCHP, including any limitations or exclusions. To be covered, all services and supplies must be medically necessary as determined by your network provider and the plan.

Ambulance

Emergencies:

In emergencies, the plan covers ambulance transportation to the nearest appropriate medical facility. Call your local emergency communications system (e.g., police or fire department, or 911) to request an ambulance. For more information about emergency situations, see "Emergency and urgent care" on pages 78 and 79.

Emergency services do not require authorization, but you must notify the plan of any emergency services that you receive (see the "Emergency and urgent care" section on pages 78 and 79). The type of ambulance used (air ambulance, land ambulance, etc.) must be appropriate to medical condition and geographic location.

Nonemergency situations:

Ambulance service for medical treatments and procedures may be provided for certain nonemergency situations, when medically necessary. Any such service must be referred by a plan physician and authorized in advance by the plan. Transportation by any other means must be contraindicated by your medical condition.

Nonemergency transportation may also be considered if a member requires a medically necessary treatment or procedure and is nonambulatory both before and after the ordered treatment or procedure. Medivan transportation may be authorized in lieu of ambulance transportation if criteria are met for consideration of transportation approval. We reserve the right to determine the appropriate vehicle which meets criteria for transportation.

Service	Benefit
1. Ambulance transportation for an emergency	Covered in full
2. Ambulance transportation for preauthorized nonemergency transfers	Covered in full

Exclusions

1. Ambulance use for transportation services only, including elective chair van transport from long-term care facilities to medical appointments
2. Transfers between hospitals when your medical condition does not warrant that you be transported to another facility
3. Air ambulance, when not appropriate to your medical condition or geographic location
4. Commercial airline transportation

Emergency and urgent care

Emergency care

The plan covers emergency care worldwide. When you have an emergency medical condition, you should go to the nearest emergency room for care or call your local emergency communications system (e.g., police or fire department, or 911).

An emergency medical condition is a condition, whether physical or mental, manifesting itself by symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of prompt medical attention to result in:

1. serious jeopardy to the health of the member or another person (or unborn child)
2. serious impairment to bodily functions, or
3. serious dysfunction of any bodily organ or part.

Examples of covered emergencies are stroke, unconsciousness, heart attack symptoms or severe bleeding.

Emergency services do not require plan authorization, but you must notify the plan of any emergency services that you receive. Within 48 hours after receiving emergency care, or as soon as medically possible, you or someone on your behalf should notify the plan. You may also wish to notify your PCP so that he or she can make arrangements to coordinate your care. Your PCP will work with the plan to assure that any follow-up or continuing care that is medically necessary will be arranged for you.

Urgent care

Sometimes you may need care right away for minor emergencies such as cuts that require stitches, a sprained ankle or abdominal pain. These situations may not pose as much of a threat as the emergency situations discussed above, but they still require fast treatment to prevent serious deterioration of your health.

If you are within the service area, call your PCP's office for authorization to seek treatment. If your doctor is not available, a doctor on call will make arrangements for your care. Network providers telephones are answered 24

hours a day, 7 days a week. Explain the medical situation to the doctor and state where you are calling from, so that the doctor can refer you to the most appropriate facility.

If you are outside the service area, go to the nearest medical facility for care. Within 48 hours after receiving emergency care, you or someone on your behalf should notify your PCP and the plan at 1-866-344-4GIC.

Service	Benefit
1. Emergency room visits	Emergency room copayment
2. Emergency room visits when you are admitted to an observation room	Emergency room copayment
3. Emergency room visits when you are admitted as an inpatient	Covered in full
4. Urgent care visits in a provider's office or at an urgent care facility (authorized visits only)	Urgent care copayment

Exclusions

1. Unauthorized in-area urgent care visits
2. Out-of-area care or services that could have been anticipated before leaving the plan service area
3. Follow-up care, unless provided by your PCP or authorized by the plan. This exclusion includes follow-up care in an emergency room setting

Home health care services

The plan covers skilled services provided in your home by a home health agency. Skilled services include nursing, physical therapy, occupational therapy and speech therapy.

Covered services include the services of a home health aide, medical social worker or nutritionist, and durable medical equipment and supplies ordered by your physician for the treatment and diagnosis of your injury. These items and services are covered to the extent they are a medically necessary component of covered nursing and physical therapy. Please note that durable medical equipment provided as part of your health care services is not subject to a coinsurance payment (see pages 106 and 108 for more information on durable medical equipment coverage and exclusions).

Home health care services must be ordered by a plan physician and authorized by the plan. (See pages 19 to 20 for more information.)

Service	**Benefit**
1. Skilled nursing care	Covered in full
2. Physical, occupational and speech therapy	Covered in full
3. Medical social services	Covered in full
4. Home health aide services	Covered in full
5. Medical and surgical supplies and durable medical equipment	Covered in full
6. Nutritional consultation	Covered in full
7. Hospice care services	Covered in full

Exclusions

1. Personal comfort items
2. Meals
3. Housekeeping services
4. Custodial care services

Hospice care

The plan provides coverage for hospice care services. Hospice care is a method for caring for the terminally ill that helps those individuals continue their lives with as little disruption as possible. This type of care emphasizes supportive services, such as home care and pain control, rather than the cure-oriented services provided in hospitals.

Hospice services may include, but are not limited to, physician's services; nursing care provided by or under the supervision of a registered nurse; occupational, physical and speech therapy for purposes of symptom control or to enable the individual to maintain activities of daily living; medical supplies and appliances; drugs that cannot be self-administered; medical social services; volunteer services; and counseling services provided by professional or volunteer staff under professional supervision.

Hospice care services require a referral from your PCP and plan authorization. (See pages 19 to 20 for more information.)

Service	**Benefit**
1. Hospice services provided in your home by a home health agency	Covered in full
2. Physician's services provided in your home or hospice facility	Covered in full
3. Inpatient respite care in a hospice or skilled nursing facility for up to five consecutive days.	Covered in full

Exclusions

1. Long-term rehabilitative care
2. Personal comfort items such as television, radio or telephone
3. Inpatient respite care beyond five consecutive days

Hospital inpatient services

The plan covers inpatient care for as many days as your condition requires. Your network provider will work with FCHP's Health Management Services Department to develop a treatment plan for you.

If you are in a hospital or other medical facility when your coverage takes effect, you will be covered by the plan as of your effective date as long as you notify us as soon as medically possible that you are an inpatient. You must also allow a network provider to assume further care. If medically appropriate, you may be transferred to a network facility.

Hospital inpatient services require referral and authorization (see pages 19 to 20 for more information on referral and authorization). Whenever you need to be admitted to a hospital for a medical procedure, your PCP and specialty care physician will work with us to obtain authorization at a network facility to which your physician admits. Your physician and the plan also will monitor the care that you receive as an inpatient and coordinate your discharge from the hospital. While you are inpatient, our case management program will review and evaluate the inpatient care that you receive to make sure that you receive appropriate care. For more information about case management review, see the "Utilization review" section on page 24.

Service	**Benefit**
1. Inpatient hospital care for as many days as medically necessary, including room and board in a semiprivate room (or private room if medically necessary) and the services and supplies that would ordinarily be furnished to you while you are an inpatient. These include, but are not limited to, diagnostic lab and x-ray services; anesthesia services; medications; meals; nursing care; physical, occupational and speech therapy; medical and surgical supplies; oxygen and respiratory therapy;	Inpatient copayment

Service	Benefit
blood and its administration; and operating and recovery room services.	
2. Professional services provided while you are an inpatient, including, but not limited to, medical, surgical or psychiatric physician's services; and the services of a certified registered nurse anesthetist or nurse practitioner.	Covered in full

Exclusions

1. Private room, unless medically necessary. If you desire a private room and it is not a medical necessity, you pay all additional room charges above the semiprivate room charge.
2. Personal comfort items such as telephone, radio or television
3. Charges that you incur for services not determined to be medically necessary by a plan physician and the plan, or when you choose to stay beyond the hospital discharge hour for your own convenience

Infertility/assisted reproductive technology services

The plan covers the services shown below for diagnosis and treatment of infertility. Infertility is defined as "the condition of a presumably healthy individual who is unable to conceive or produce conception during a period of one year." To meet criteria, you must be an individual who: (1) should expect fertility as a natural state, and (2) is a premenopausal female or a female who is experiencing menopause at a premature age. Approval for assisted reproductive technology (ART) is contingent upon review by the medical director of the enrollee's medical history. FCHP's coverage guidelines for all ART services are available by contacting the Customer Service Department.

Infertility services require referral and authorization (see pages 19 to 20 for more information). Original approval is for four ART cycles; if you wish to continue beyond four cycles, further medical review by the medical director is required.

Service	**Benefit**
1. Office visits for the diagnosis and treatment of infertility	Office visit copayment
2. Diagnostic laboratory and X-ray services	Covered in full
3. The following assisted reproductive technology procedures: • Artificial insemination • In vitro fertilization and embryo placement • Gamete intrafallopian transfer • Zygote intrafallopian transfer • Intracytoplasmic sperm injection for the treatment of male factor infertility	Covered in full

- Sperm, egg and/or inseminated egg procurement and processing and banking of sperm or inseminated eggs, to the extent such costs are not covered by the donor's insurer

Exclusions

1. Services or supplies that have not been determined to be medically necessary by a plan specialist in fertility and the plan medical director, or when the member has a medical contraindication, or when there is no diagnosis of infertility
2. Services that are considered experimental or which have not been approved by the plan medical director
3. Donor egg transfer or harvesting for women who are menopausal (except as stated above) or have genetic oocyte defects
4. Chromosome studies of a donor (sperm or egg)
5. Pre-implant Genetic Diagnosis (PGD) or testing—genetic testing on the embryo before it is inserted into the uterus
6. Charges for the storage of donor sperm, eggs or embryo that remain in storage after the completion of an approved infertility cycle
7. Service fees, charges or compensation for a donated egg (This exclusion does not include the charges related to the medical procedure of removing an egg for the purpose of donation when the recipient is a member of the plan.)
8. Supplies that may be purchased without a physician's written order, such as ovulation test kits
9. Services that are necessary due to a voluntary sterilization, such as tubal ligation or vasectomy
10. Services that are covered by another insurer
11. Surrogacy or gestational carrier services
12. Transportation costs to or from the medical facility

Maternity services

The plan covers the maternity and obstetrical services shown below. Routine obstetrical and maternity service does not require a referral or authorization, but you need to see a network provider who is an obstetrician, certified nurse midwife or family practice physician. (See page 18 for more information.) Nonroutine care of the newborn, such as the medical or surgical treatment of congenital defects, birth abnormalities or premature birth, are covered when the newborn is enrolled as a dependent under the subscriber's family coverage.

Service	**Benefit**
1. Prenatal and postpartum care provided by a network physician or certified nurse midwife copayment (first prenatal visit only);	Prenatal: OB/GYN office visit Postpartum: OB/GYN office visit copayment
2. Inpatient hospital charges for childbirth including room and board in a semiprivate room for a minimum of 48 hours of care following a vaginal delivery, or 96 hours of care following a Caesarean section delivery and the services and supplies that would ordinarily be furnished to you while you are an inpatient (see "Hospital inpatient services" on page 82 for a list of covered services and supplies).	Inpatient copayment
3. Routine care of the newborn provided during the maternity admission including: nursery charges, circumcision, routine examination and hearing screening. The covered length of stay may be reduced if the mother and the attending physician agree upon an earlier discharge. If you or your newborn are discharged earlier, one home visit by a registered nurse,	

Service	Benefit
physician or certified nurse midwife is covered.	
4. Professional and ancillary charges related to the delivery.	Covered in full

Exclusions

1. Charges related to a maternity admission for a full-term pregnancy outside the plan service area (including the related newborn child care), or which has not been arranged by a network provider and authorized by the plan
2. Private room, unless medically necessary. If you desire a private room and it is not a medical necessity, you are responsible for all additional room charges above the semiprivate room charge.
3. Personal comfort items such as telephone, radio or television
4. Charges that you incur for services not deemed medically necessary by a plan provider and the plan, or when you choose to stay beyond the hospital discharge hour for your own convenience
5. Routine circumcision performed following discharge (unless the delay was required due to the infant's medical condition)
6. Charges for a home birth

Mental health

The plan covers the diagnosis and treatment of mental conditions on an outpatient, intermediate or inpatient basis. A mental condition is defined as a condition that is described in the most recent edition of the *Diagnostic and Statistical Manual* of the American Psychiatric Association, and that is determined as such by a network provider and the plan. The level of care needed and the program used must be authorized by a plan psychiatrist. Treatment may be provided by a psychiatrist, psychologist, psychotherapist, licensed nurse mental health clinical specialist, licensed independent clinical social worker, mental health counselor, pediatric specialist or other provider as authorized by the plan.

A member who loses eligibility as a dependent upon reaching age 19 and is receiving ongoing mental health treatment at the time may be eligible to continue coverage for the treatment. Call Customer Service for more information (members who lose eligibility as a dependent may also continue full coverage under COBRA; see page 67).

For mental health emergencies, follow the same procedures as for any other medical emergency (see page 78).

Inpatient services

The plan covers mental health services in an inpatient setting, when authorized by the plan. To access services and obtain authorization, call 1-888-421-8861 (TDD/TTY: 781-994-7660). Coverage is provided for inpatient care when medically necessary in a licensed or accredited general hospital, or in a licensed or accredited psychiatric hospital (or its equivalent in an alternative program). Levels vary from least to most restrictive and include: respite or crisis stabilization, day or evening treatment or partial hospitalization, short-term residential treatment and hospital-based programs.

For those members being treated for mental health and substance abuse, the plan also covers care in an inpatient substance abuse facility or level III (medically monitored 24-hour residential) community-based detoxification facility.

Service	Benefit
1. Inpatient care for as many days as your condition requires, including room and board and the services and supplies that would ordinarily be furnished to you while you are an inpatient (see Hospital inpatient services for a list of covered services and supplies). These include, but are not limited to, psychopharmacological and neuro-psychological assessment services, and individual, family and group therapy.	Covered in full
2. Professional services provided by physicians or other health care professionals	Covered in full

Intermediate services

Members may receive mental health care in an alternative setting in lieu of inpatient hospitalization. This may include, but is not limited to, day and evening treatment programs.

Service	Benefit
1. Mental health care provided in an alternative setting, such as crisis intervention, mental health at home, day or evening treatment, acute residential or other treatment as appropriate and when authorized by the plan.	Covered in full

Outpatient services

Members may self-refer for outpatient mental health services. For assistance in finding a network provider, call 1-888-421-8861 (TDD/TTY: 1-781-994-7660). The plan covers medically necessary mental health services of a network provider, in an outpatient setting, as follows:

Service	Benefit
1. Outpatient office visits, including individual group or family therapy. The actual number of visits provided is based on medical necessity as determined by your network provider and the plan, and may include individual, group or family therapy.	Mental health office visit copayment
2. Psychopharmacological services, such as visits with a physician to review, monitor or adjust the levels of prescription medication used to treat a mental condition	Office visit copayment
3. Neuropsychological assessment services, when medically necessary	Office visit copayment

Exclusions

1. Services that have not been authorized by the plan, including nonemergency services received out-of-area
2. Treatment for personal growth development or certification, or other treatment that is not medically necessary
3. Ancillary services such as vocational rehabilitation, behavioral training, sleep therapy, employment or vocational counseling and training, or educational therapy for learning disabilities, or other educational services such as educational testing
4. Inpatient charges for a private room, unless medically necessary (if you desire a private room and it is not a medical necessity, you pay all additional charges above the semiprivate room charge); charges for personal comfort items such as telephone, radio and television; and charges that you incur when you choose to stay beyond the hospital or program discharge hour for your own convenience
5. Services requested by a third party that are not medically necessary, including court-ordered treatment or evaluations; educational evaluations; and competency, adoption or child custody/visitation evaluations
6. Alternative therapies that do not include face-to-face participation by the member (e.g., "phone therapy")

7. Psychological testing unless determined to be medically necessary
8. Elective long-term psychotherapy
9. Mediation or intervention services
10. Faith-based counseling (e.g., Christian counseling)
11. Inpatient treatment for conditions that are often described as sexual addiction, compulsive gambling, co-dependency, or for adult children of non-abusing family members; aversion treatment; structured sexual therapy programs, including the use of surrogates; or services and treatment not in keeping with national standards of practice, as determined by the plan's medical director and his/her designees, including but not limited to nutritional based therapies, crystal healing therapy, Rolfing®, regressive therapy, EST, and herbal therapy

Office visits and outpatient services

The plan provides coverage for the services listed below. Pediatric specialty care, including mental health care, is covered when provided to a member requiring such services by a provider with recognized expertise in specialty pediatrics. Specialty services generally require referral and authorization. (See pages 18 to 20 for more information.)

The plan covers the costs for services furnished to members enrolled in certain qualified clinical trials. To be eligible for coverage, you must have been diagnosed with cancer, and the clinical trial must be one that is intended to cure cancer. Treatment must be consistent with the usual and customary standard of care for someone with the same diagnosis. Coverage is limited to those services covered by the plan and subject to all the terms and conditions of the plan, including, but not limited to, provisions requiring the use of network providers.

Service	**Benefit**
Office visits and related services	
1. Office visits to diagnose or treat an illness or an injury, including • Physician home visits • A second opinion, upon your request, with another network provider • Respiratory therapy services • Hormone replacement therapy services for perimenopausal and postmenopausal women	Office visit copayment
2. Radiation therapy	Covered in full
3. Injections and injectables that are included on the formulary, that are for covered medical benefits, and that are ordered, supplied and administered by a network provider	Covered in full

Service	Benefit
4. Allergy testing and allergy injections	Covered in full
5. Diagnostic lab and x-ray services	Covered in full
6. Outpatient renal dialysis at a network facility or continuous ambulatory peritoneal dialysis	Covered in full
7. Audiological examination for the purpose of prescribing a hearing aid. Coverage is limited to one exam every two years.	Office visit copayment
Office visits and outpatient services	
8. Diabetic services, including:	
• Diabetes outpatient self-management training and education, including medical nutrition therapy, provided by a certified diabetes health care provider	Office visit copayment
• Laboratory tests necessary for the diagnosis and treatment of diabetes, including glycosylated hemoglobin, or HbA1c tests, and urinary protein/ microalbumin and lipid profiles	Covered in full
9. Chiropractic services for acute musculo-skeletal conditions. The condition must be new or an acute exacerbation of a previous condition. Coverage is provided for up to 20 visits in each calendar year. The actual number of visits covered is based on medical necessity as determined by your provider the plan.	Chiropractic office visit copayment
10. Medical social services provided to assist you in adjustment to your or your family member's illness. This includes assessment, counseling, consultation and assistance in accessing community resources.	Office visit copayment

Service	Benefit
11. Voluntary family planning services including: • Consultations, examinations, procedures and medical services related to the use of all contraceptive methods; reproductive health education and disease prevention; genetic counseling; and elective sterilization • Contraceptive devices that are supplied by a network provider during an office visit • Termination of pregnancy in an office setting (*Note:* termination of pregnancy or other procedures provided in a hospital outpatient, day surgery or ambulatory care facility are subject to the outpatient surgery copayment.)	Office visit copayment
12. Outpatient surgery, including anesthesia and the medically necessary pre- and post-operative care related to the surgery, provided in a hospital outpatient, day surgery or ambulatory care facility	Outpatient surgery copayment

Discounts on products and services

FCHP has arranged for member discounts on products and services, such as eyeglasses, contact lenses, hearing aids, acupuncture, massage therapy and fitness club memberships. These discounts are not part of your plan benefits and no referral or preauthorization is necessary. Call Customer Service or visit our Web site at www.fchp.org for more information on these and other discounted products and services and the names of participating providers in your area.

Health education and wellness programs

In addition to providing health care coverage for our members, FCHP

offers a variety of health education classes, support groups and wellness programs for people in our community who want to take an active role in their health care. These include:

- CPR
- Child passenger safety
- Smoking cessation
- Osteoporosis support group
- Stress management
- Nutrition classes

Fees for these programs vary and many are provided at no cost. Call Customer Service or visit our Web site at www.fchp.org for more information on these and other health education and wellness programs.

Exclusions

1. Routine foot care such as trimming of corns and calluses, treatment of flat feet or partial dislocations in the feet
2. Exams or treatment required by a third party unless medically necessary as determined by a network provider and the plan. Examples are pre-employment or school physicals, premarital medical tests, court-ordered treatment or immunizations required due to your job or work conditions.
3. Acupuncture or massage therapy
4. Visits to additional providers beyond a second opinion, or a second opinion with a non-network provider.

Oral surgery and related services

The plan covers the services listed below. All services must be provided by a network oral surgeon or physician (this does not include a dentist).

You do not need a referral or authorization for extraction of impacted teeth or for emergency care. All other services shown below require referral and authorization. (See pages 18 to 20 for more information.)

Service	**Benefit**
1. Office visits with an oral surgeon for: • The removal or exposure of impacted teeth, including both hard- and soft-tissue impactions, or an evaluation for this procedure • The surgical treatments of cysts affecting the teeth or gums that cannot be treated by a dentist • The treatment of fractures of the jawbone (mandible) • The evaluation and surgery for the treatment of temporomandibular joint disorder when a medical condition is diagnosed	Office visit copayment
2. Emergency medical care such as to relieve pain and stop bleeding as a result of accidental injury to the sound natural teeth or tissues when provided as soon as medically possible after injury. This does not include restorative or other dental care. You do not need authorization for emergency care. Go to the closest provider and notify FCHP within 48 hours of receiving care.	Office visit copayment

Limited services

Benefits are provided for the following procedures only when you have a serious medical condition that makes it essential that you be admitted to a hospital as an inpatient, or to a surgical day care unit or ambulatory surgical facility as an outpatient, in order for the dental care to be performed safely. Serious medical conditions include but are not limited to hemophilia and heart disease. Refer to page 82 for a description of hospital inpatient services, or page 94 for outpatient surgery coverage.

- Extraction of seven or more teeth
- Gingivectomies (including osseous surgery) of two or more gum quadrants
- Excision of radicular cysts involving the roots of three or more teeth
- Removal of one or more impacted teeth

Exclusions

1. Procedures or services related to dental care, including restorative dental care and permanent restoration of injured teeth, except as shown above as covered. Noncovered services also include but are not limited to: root canals, extractions, orthodontia, periodontal surgery, endodontic and prosthodontic services, bonding and devices such as bridges, dentures, implants, crowns or caps.
2. Dental treatments and appliances for the treatment of temporomandibular joint disorder
3. Services that have not been referred by a network provider and authorized by the plan, or services provided by a non-network oral surgeon (with the exception of the extraction of impacted teeth or emergency care services as specified in number 2 above)
4. Services for cosmetic reasons, such as whitening
5. Inpatient dental care, except as shown above under "Limited services"

Organ transplants

The plan covers certain human solid organ, bone marrow and stem cell transplants. This includes bone marrow transplant or transplants for persons who have been diagnosed with breast cancer that has progressed to metastatic disease.

If you are the recipient of a transplant, the services for the donor are covered including the evaluation and preparation, and the surgery and recovery directly related to the donation, except for those services covered by another insurer. If you are the donor and the transplant recipient is not a member of the plan, no coverage is provided for either the recipient or the donor, except for human leukocyte antigen or histocompatibility locus antigen testing described in service number 4 below.

The transplant must be performed at an affiliated transplant facility, subject to your acceptance into the program. The plan will work with the transplant facility to coordinate your care during the evaluation and transplant process and help to arrange your discharge and follow-up care.

If you want a second opinion, the plan will identify another suitable transplant facility. Additional opinions beyond a second opinion are not covered. Transplant services require a referral from your PCP and plan preauthorization (see pages 18 to 20 for more information on obtaining specialty care and services).

Service	**Benefit**
1. Office visits related to the transplant	Office visit copayment
2. Inpatient hospital services, including room and board in a semiprivate room and the services and supplies that would ordinarily be furnished to you while you are an inpatient	Inpatient copayment
3. Professional services provided to you while you are an inpatient, including, but not limited to medical, surgical and psychiatric services	Covered in full
4. Human leukocyte antigen (HLA) or histocompatibility locus antigen testing	Covered in full

for A, B or DR antigens, or any combination thereof, necessary to establish bone marrow transplant donor suitability of a member.

Exclusions

1. Investigational or experimental procedures, including but not limited to:
   - the transplant of partial pancreatic tissue or islet cells
   - a pancreatic transplant that does not follow a kidney transplant or that is not part of a combined pancreas-kidney transplant
2. Bioartificial transplantation, such as the transplant of a total artificial heart.
3. Xenotransplantation, such as the transplant of animal tissues or organs into human.
4. Services for the organ donor that are covered by another insurer.
5. Services for an organ donor if the recipient is not a member of the plan.
6. Transportation or housing costs for the recipient or donor.
7. House cleaning costs incurred in preparation for a transplant recipient's discharge.

Prescription medication

The plan covers medically necessary prescription drugs according to the requirements and guidelines discussed below.

Who can write your prescription

A network provider, including a provider whom you have seen on an authorized referral, can write your prescription.

Where you can fill your prescription

You can fill your prescription at a network pharmacy or through our mail order program. The provider directory has a listing of network pharmacies.

The FCHP prescription drug formulary

The FCHP prescription drug formulary is a list of covered medications that shows the copayment tier and prior authorization requirements for each medication. A committee of doctors and pharmacists reviews and updates the formulary regularly.

The FCHP prescription drug formulary has a three-tiered copayment structure. We have selected the tiers based on efficacy and cost-effectiveness. There is a different copayment for each tier. Tier-1 drugs have the lowest copayment, Tier-2 drugs have the next lowest copayment, and Tier-3 drugs have the highest copayment. See the addendum enclosed in this *Member Handbook* for your prescription medication copayments.

Certain drugs in the formulary are covered only when we determine that they are medically necessary for you. For these drugs, your doctor should request authorization from FCHP before he or she writes the prescription and give us the clinical information that we need to make our decision. We will review the authorization request according to our criteria for medical necessity. The drugs that require prior authorization are marked on the formulary.

The prescription drug formulary is available at our website at www.fchp.org. If you do not have access to our website or if you have any questions about the formulary, please call Customer Service.

Drugs not shown on the FCHP prescription drug formulary

In certain circumstances, your provider may want to prescribe a drug that is not listed on the prescription drug formulary. A drug may not be included in the formulary because it is new or because it is very infrequently used. Coverage for any drug not listed in the prescription drug formulary requires prior authorization from the plan. Drugs that are approved for coverage which are not listed in the formulary are assigned to Tier 3.

Off-label use of drugs to treat cancer or HIV/AIDS

The plan will cover drugs that are approved by the U.S. Food and Drug Administration (FDA), and the costs to administer such drugs, if your doctor prescribes them for the treatment of cancer or HIV/AIDS even if the FDA has not approved the drug for that use. In no event will the plan pay for experimental drugs which have not been approved for use by the FDA.

Dispensing limitations

Prescription drugs are generally dispensed for up to a 30-day supply. In some instances, the plan has established dispensing limitations. Sometimes, for safety reasons or as directed by your prescriber, the length of therapy may be less than 30 days. For maintenance medication, your prescription may be for a 90-day supply. We follow FDA dispensing guidelines. You generally cannot obtain a refill until most or all of the previous supply has been used.

Generic and brand-name drugs

A generic drug is a drug product that meets the approval of the U.S. Food and Drug Administration and is equivalent to a brand-name product in terms of quality and performance. It may differ in certain other characteristics (e.g., shape, flavor or preservatives). By law, generic drug products must contain identical amounts of the same active drug ingredient as the brand-name product.

You will generally receive a generic drug from network pharmacies anytime one is available, unless your doctor has directed the pharmacist to only dispense a specific brand-name drug. However, there are some brand-name drugs that do not have a generic equivalent. In both of these cases, you will be responsible for the copayment for the actual drug dispensed.

Mail-order prescriptions

You may also get your prescription medication refill(s) through our mail-order program. You may have your prescription mailed directly to you at home or at any other location if you are traveling within the country. Most medications can be mailed; however, there are some that may not. Some diabetic supplies also may not be available through mail order. Your pharmacist will make the determination.

When you fill a prescription through our mail-order program, you pay a fixed copayment for each tier of medication for up to a 90-day supply.

- Your mail-order copayment for up to a 90-day supply of Tier-1 medication is equal to two (30-day supply) Tier-1 pharmacy copayments.
- Your mail-order copayment for up to a 90-day supply of Tier-2 medication is equal to two (30-day supply) Tier-2 pharmacy copayments.
- Your mail-order copayment for up to a 90-day supply of Tier-3 medication is equal to three (30-day supply) Tier-3 pharmacy copayments.

See the addendum enclosed in this *Member Handbook* for your mail-order prescription copayments.

Emergency prescription medications

In emergency situations where you cannot obtain your prescription from a network pharmacy, the plan will provide coverage for up to a 14-day supply of an emergency medication. You may fill the prescription at any convenient location and submit the receipt for reimbursement. You will be reimbursed the cost of a 14-day supply, minus the applicable copayment. See page 40 for information on submitting a claim.

New members

If you are a new member and need to have an existing prescription refilled, we encourage you to see your PCP to review your prescriptions. If you are currently taking a drug that requires prior authorization, your doctor will need to submit a request for prior authorization. We will determine coverage of that drug based on our criteria for medical necessity. Or, if the drug you are currently taking is a Tier-3 drug, you may want to discuss alternatives with your doctor.

Covered items:

- Prescription medication
- Contraceptive drugs and devices
- Hormone replacement therapy
- Injectable agents (self-administered*)
- Insulin
- Insulin syringes
- Supplies for the treatment of diabetes, as required by state law, including:
  - blood glucose monitoring strips
  - urine glucose strips
  - ketone strips
  - lancets
  - insulin pumps and insulin pump supplies
  - insulin pens, for the treatment of diabetes
- Prescribed oral medications that influence blood sugar levels, for the treatment of diabetes, as required by state law

** Injectables administered in the doctor's office or under other professional supervision are generally covered as a medical benefit.*

Exclusions

1. Drugs that you can buy without a prescription. This exclusion does not apply to insulin and other diabetes-related medications that are shown above as covered items.
2. Drugs that are investigational or that have not been approved for general sale and distribution by the U.S. Food and Drug Administration.
3. Drugs that require prior authorization if prior authorization is not received.
4. Drugs prescribed for purposes that are not medically necessary or that are associated with noncovered benefits, such as for cosmetic purposes, to enhance athletic performance, for appetite suppression, or for noncovered conditions. This also includes drugs that do not meet medical criteria.
5. Prescriptions obtained within the plan service area at a non-network pharmacy.
6. Nonemergency prescriptions filled outside the plan service area.
7. Vitamins and minerals, whether or not a prescription is required
8. Over-the-counter birth control preparations or devices.

Preventive care

The plan covers the routine and preventive services listed below. Services must be provided or referred by a network provider. Services do not require referral and authorization unless otherwise indicated. (See pages 18 to 20 for more information on referral and authorization.)

Service	**Benefit**
1. Periodic physical exams with your PCP for the prevention of disease	Office visit copayment
2. Immunizations that are included on the FCHP formulary, that are for covered medical benefits and that are ordered, supplied and administered by a plan physician. If administered by a specialist, you will generally need to obtain a referral to see the specialist.	Covered in full
3. A baseline mammogram for women age 35 to 40, and a yearly mammogram for women age 40 and older	Covered in full
4. Routine gynecological care services, including an annual Pap smear for women age 18 and older	Office visit copayment
5. Routine eye exams, once in each 12-month period	Office visit copayment
6. Hearing and vision screening performed during a physical exam	Covered in full
7. Pediatric wellness visits with your child's PCP. At least six times during the child's first year after birth, at least three times during the next year, then at least annually until the child's nineteenth birthday. This includes the following preventive care services, as recommended by the physician and in accordance with state law: • physical examination	Office visit copayment

- history
- measurements
- sensory screening, including hearing and vision
- neuropsychiatric evaluation
- development screening and assessment
- lead poisoning screening
- hereditary and metabolic screening at birth
- newborn hearing screening test performed before the newborn infant is discharged from the hospital or birthing center
- tuberculin tests
- hematocrit, hemoglobin, and other appropriate blood tests and urinalysis

8. Coronary artery disease secondary prevention program for members with a history of heart disease. This is a program that helps you reduce your heart disease factors through lifestyle changes. Members completing the program are eligible for a $100 reimbursement of the copayment amount. Contact Customer Service for more information. — $200 copayment

Exclusions

1. More than one routine eye examination in each 12-month period, or eye examinations/fitting for contact lenses
2. Eyeglasses or contact lenses (except intraocular lenses implanted following cataract surgery)
3. Exams or treatment required by a third party unless medically necessary as determined by a network provider and the plan. Examples are pre-employment or school physicals, premarital medical tests, court-ordered treatment or immunizations required due to your job or work conditions.
4. A voluntary termination of pregnancy provided by a non-network provider. Coverage is provided for unforeseen emergencies, or urgent conditions of the fetus or mother, while out of the plan service area.

Prosthetic/orthotic devices and durable medical equipment

The plan covers the purchase or rental of medically necessary prosthetic/orthotic devices and durable medical equipment as described below. The plan pays 80% for most covered items, and you are responsible for the remaining 20%. Some items, such as hearing aids, are subject to calendar year maximums.

The purchase or rental of prosthetic/orthotic devices and durable medical equipment requires referral and authorization. (See pages 18 to 20 for more information.) Coverage is provided for either the rental or purchase of the least expensive prosthetic/orthotic device or durable medical equipment that meets your needs, as determined by a network physician and the plan. The plan will determine if the equipment or device will be rented or purchased. Coverage is also provided for the replacement of, and replacement parts for, authorized durable medical equipment.

Prosthetic devices are devices that replace all or part of an organ or body part (other than dental). Some examples are:

- Artificial limbs and eyes
- Implanted corrective lenses needed after a cataract operation
- Breast and hair prosthesis
- Electric speech aids

Orthotic devices are "rigid or semi-rigid" devices that support part of the body and/or eliminate motion. Some examples are:

- A form neck collar for cervical support
- A molded body jacket for curvature of the spine (scoliosis)
- An elbow or leg brace
- Back, neck or leg braces with rigid supports, including orthopedic shoes that are part of braces
- Splints
- Therapeutic/molded shoes and shoe inserts for the treatment of severe diabetic foot disease

Durable medical equipment is defined as an item for external use that can withstand repeated use, is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of illness or injury, and is appropriate for use in a patient's home. Durable medical equipment includes such items as:

- Oxygen
- Oxygen equipment
- Respiratory equipment
- Hospital beds
- Wheelchairs
- Crutches, canes and walkers
- Breast pumps
- Blood glucose monitors for home use, for the treatment of diabetes
- Visual magnifying aids and voice synthesizers for blood glucose monitors, for use by diabetics who are legally blind

Service	Benefit
1. The purchase or rental of prosthetic/orthotic devices and durable medical equipment (including the fitting, preparing, repairing and modifying of the appliance)	20% coinsurance
2. Hearing aid(s) when prescribed by a plan physician and obtained from a network provider. Coverage is limited to once in each two-calendar year period.	The first $500 of the purchase price is covered in full; you pay 20% of the next $1,500 of the purchase price plus all additional costs.
3. Scalp hair prosthesis (wigs) for individuals who have suffered hair loss as a result of the treatment of any form of cancer or leukemia. Coverage is provided for up to $350 per member per calendar year when the prosthesis is determined to be medically necessary by a plan physician and the plan.	20% coinsurance

4. Oxygen and related equipment	20% coinsurance
5. Breast prosthesis that is medically necessary after a covered reconstructive surgery following a mastectomy	Covered in full

Exclusions

1. Items that are not covered include, but are not limited to: air conditioners, air purifiers, arch supports, ear plugs (i.e., to prevent fluid from entering the ear canal during water activities), foot orthotics, orthopedic shoes (except when part of a brace) or other supportive devices for the feet, articles of special clothing, compression garments, bedpans, raised toilet seats, dehumidifiers, dentures, elevators, safety grab bars, car seats, seizure helmets, heating pads, hot water bottles, exercise equipment or similar devices.
2. Oxygen and related equipment, when received from a non-network provider. This includes oxygen and related equipment that you are supplied with while you are out of the plan service area.
3. Charges for hearing aids in excess of $2,000 (purchase price) per two-calendar-year period
4. Scalp hair prosthesis in excess of the calendar year limit or for medical conditions other than those described above

Reconstructive and restorative surgery

The plan covers reconstructive or restorative surgical services rendered in an ambulatory surgical facility, a surgical day care unit, a general hospital, community health center, or by a physician. Reconstructive and restorative surgery are covered in full subject to the normal inpatient and outpatient copayments and exclusions.

Reconstructive surgery is covered for improving or restoring bodily function, or correction of functional physical impairment, resulting from an accidental injury, a disease, a congenital anomaly, or a previous non-cosmetic surgical procedure. Services require referral and authorization. (See pages 18 to 20 for more information.)

Restorative surgery is covered for repair of physical appearance, damaged by accidental injury or disease. Services require referral and authorization. (See pages 18 to 20 for more information.)

Some examples of covered procedures are:

- Reconstructive surgery to repair a condition resulting from injury, birth defect or non-cosmetic surgery
- Removal of breast implants due to the complications of non-cosmetic surgery or autoimmune disease
- Reconstructive surgery following a mastectomy including:
- reconstruction of the breast on which the mastectomy was performed
- surgery and reconstruction of the other breast to produce a symmetrical appearance
- prostheses* (for example, breast implants) and treatment for the physical complications of the mastectomy including lymphedema

Surgery for cosmetic reasons is not covered, whether intended to improve an individual's emotional outlook or to treat a mental health condition. Examples include face-lifts and the removal of nonmalignant skin lesions and skin tags.

** Coverage for prostheses is described under prosthetic/orthotic devices and durable medical equipment on page 106.*

Service	Benefit
1. Office visits related to the surgery	Office visit copayment
2. Reconstructive surgery in a hospital outpatient, day surgery or ambulatory care facility, including anesthesia and the medically necessary pre- and post-operative care related to the surgery	Outpatient surgery copayment
3. Inpatient hospital charges for reconstructive or restorative surgery, including room and board and the services and supplies that would ordinarily be furnished to you while you are an inpatient (see "Hospital inpatient services" on page 82 for a list of covered services and supplies)	Inpatient copayment
4. Professional services related to the surgery, including but not limited to medical, surgical and psychiatric services.	Covered in full

Exclusions

1. Services for cosmetic reasons

Rehabilitation services

The plan covers outpatient rehabilitation services as indicated below. Short-term rehabilitation services such as physical and occupational therapy are limited to a 90-day period per acute episode beginning with the first office visit. Medical necessity determines the actual number of visits covered.

Services require referral and authorization. (See pages 18 to 20 for more information.)

Service	Benefit
1. Short-term rehabilitation services. This includes physical and occupational therapy to restore function after medical illness, accident or injury. Coverage is provided for as many visits as are medically necessary per acute episode within a 90-day period beginning with the first office visit.	Office visit copayment
2. Services for the diagnosis and treatment of speech, hearing and language disorders when provided by individuals licensed as speech-language pathologists or audiologists in a network hospital, clinic or private office setting	Office visit copayment
3. Cardiac rehabilitation for persons with documented cardiovascular disease, provided in accordance with standards developed by the Commissioner of Public Health	Covered in full
4. Early intervention services delivered by certified early intervention specialists, according to operational standards developed by the Department of Public Health, for children from birth to their 3rd birthday. Benefits are	Covered in full

limited to a maximum of $5,200 per year per child and an aggregate of $15,600 over the term of the child's plan membership.

Exclusions

1. Long-term rehabilitation services.
2. Services that are not determined to be medically necessary. This applies to physical therapy, speech therapy and occupational therapy, even if the plan limits have not yet been reached.
3. Acupuncture or massage therapy
4. Aquatic therapy
5. Early intervention services for children beyond their 3rd birthday or in excess of the benefit maximum.
6. The diagnosis or treatment of speech, hearing or language disorders in a school-based setting.

Skilled nursing facility

The plan covers inpatient services in a plan skilled nursing facility for up to 100 days in each calendar year.

You may be admitted to a skilled nursing facility if, based on your medical condition, you need daily skilled nursing care, skilled rehabilitation services or other medical services that may require access to 24-hour medical or nursing care but do not require the specialized care of an acute care hospital. Services require referral and authorization. (See pages 18 to 20 for more information.) The level of services, number of covered days that you are admitted and where you are admitted will be based upon the medical necessity of your condition as determined by your network physician and the plan.

Service	**Benefit**
1. Room and board in a semiprivate room (or private room if medically necessary), for up to 100 days in each calendar year and the services and supplies that would ordinarily be furnished to you while you are an inpatient. These include, but are not limited to, nursing services, physical, speech and occupational therapy, medical supplies and equipment.	Covered in full
2. Professional services provided while you are an inpatient, including but not limited to medical, surgical and psychiatric services.	Covered in full

Exclusions

1. Private room, unless medically necessary. If you desire a private room and it is not a medical necessity, you pay all additional room charges above the semiprivate room charge.
2. Services beyond 100 days in each calendar year

3. Services that are not determined to be medically necessary, even if the plan limit of 100 days per calendar year has not yet been reached
4. Custodial care as determined by the plan
5. Personal comfort items such as a telephone, radio or television
6. Charges that you incur when you choose to stay beyond the facility's discharge hour for your own convenience or for services that are not medically necessary as determined by your network provider and the plan

Special formulas

The plan covers the special medical formulas and food products listed below. Except for these items, the plan does not cover any nutritional formulas, supplements or food products. Covered formula and food items require referral and authorization. (See pages 18 to 20 for more information.)

Service	Benefit
1. Special medical formulas to treat certain metabolic disorders as required by state law. Metabolic disorders covered under state law include: phenylketonuria, tyrosinemia, homocystinuria, maple syrup urine disease, propionic acidemia, methyl-malonic acidemia, including when medically necessary to protect unborn fetuses of pregnant women with phenylketonuria.	Covered in full
2. Enteral formulas, upon a physician's written order, for home use in the treatment of malabsorption caused by Crohn's disease, ulcerative colitis, gastroesophageal reflux, gastrointestinal motility, chronic intestinal pseudo-obstruction, and inherited diseases of amino acids and organic acids	Covered in full
3. Food products that have been modified to be low in protein for individuals with inherited diseases of amino acids and organic acids. Coverage is provided for up to $2,500 per member, in each calendar year. You may be required to purchase these products over the counter and submit claims to the plan for reimbursement.	Covered in full

Exclusions

1. Nutritional supplements or formulas for adults or children unless they are described above as covered

Substance abuse services

The plan covers diagnosis and treatment of substance abuse conditions on an outpatient, intermediate or inpatient basis. A substance abuse condition is defined as a condition as described in the most recent edition of the *Diagnostic and Statistical Manual* of the American Psychiatric Association and that is determined as such by a network provider and the plan. The level of care needed and the program used is authorized by a plan-affiliated provider. Treatment may be provided by a certified alcohol and drug abuse counselor or other provider as authorized by the plan.

For substance abuse emergencies, follow the same procedures as for any other medical emergency (see page 78).

Inpatient services

The plan covers substance abuse services in an inpatient setting as follows, when authorized by the plan. Coverage is provided for inpatient care when medically necessary in a licensed or accredited general hospital or other public or private facility licensed by the Department of Public Health to provide detoxification or rehabilitation treatment for persons suffering from alcohol or substance abuse. To access services and obtain authorization, call 1-888-421-8861 (TDD/TTY: 781-994-7660).

Service	**Benefit**
1. Substance abuse detoxification or rehabilitation services for as many days as your condition requires, including room and board in a semiprivate room and the services and supplies that would ordinarily be furnished to you while you are an inpatient (see "Hospital inpatient services" for a list of covered services and supplies); and individual, group and family therapy	Covered in full
2. Professional services provided to you while you are an inpatient, including, but not limited to medical, surgical and psychiatric services.	Covered in full

Intermediate services

Members may receive substance abuse services in an alternative (diversionary) setting in lieu of inpatient hospitalization. This may include, but is not limited to, level III (medically monitored 24-hour residential) community based detoxification, acute residential treatment, partial hospitalization, day or evening treatment programs and state-licensed crisis stabilization services.

Service	Benefit
1. Substance abuse services provided in an alternative (diversionary) setting, such as crisis intervention, day or evening treatment, acute residential or other treatment as appropriate and authorized by the plan.	Covered in full

Outpatient services

The plan covers outpatient substance abuse services, provided in a licensed hospital, a mental health or state-licensed substance abuse clinic, a public community mental health center, a professional office, or a home-based setting, by certified alcohol and drug abuse counselors or other licensed providers authorized by the plan. Members may self-refer for outpatient substance abuse services. For help in finding a network provider, call 1-888-421-8861 (TDD/TTY: 1-781-994-7660).

Service	Benefit
1. Outpatient office visits to treat the abuse of, and/or addiction to, alcohol and drugs. The actual number of visits is determined by medical necessity, and may include individual, group and family therapies.	Substance abuse office visit copayment

Exclusions

1. Services that have not been authorized by the plan, including nonemergency services received out-of-area, or services beyond the plan benefit limits for inpatient rehabilitation for each calendar year

2. Treatment for personal growth, or other treatment that is not medically necessary, or not in keeping with national standards of practice
3. Ancillary services such as vocational rehabilitation, behavioral training, sleep therapy, employment or vocational counseling, and training or educational therapy for learning disabilities
4. Inpatient charges for a private room, unless medically necessary (if you desire a private room and it is not a medical necessity, you pay all additional charges above the semiprivate room charge); charges for personal comfort items such as telephone, radio and television; and charges that you incur when you choose to stay beyond the hospital or program discharge hour for your own convenience
5. Services requested by a third party that are not medically necessary, including court-ordered treatment or evaluations, and competency, adoption or child custody/visitation evaluations
6. Alternative therapies that do not include face-to-face participation by the member (e.g., "phone therapy")
7. Psychological testing unless determined to be medically necessary
8. Services in a residential halfway house
9. Inpatient cocaine detoxification, rapid detoxification for opiate dependency or methadone maintenance
10. Mediation or intervention services
11. Elective long-term psychotherapy
12. Faith-based counseling (e.g., Christian counseling)
13. Services and treatment not in keeping with national standards of practice, including but not limited to nonabstinence-based substance abuse treatment.

Other plan benefits and features

Out-of-area student coverage

Students attending school outside the plan service area may not have easy access to the plan's provider network. They are covered for a limited number of services while out-of-area, if authorized in advance by the plan. With the exception of emergency care, all out-of-area student services must be authorized in advance by the plan. This includes post-stabilization care or follow-up care needed as a result of an emergency.

Services covered for out-of-area students include:

- Nonroutine medical office visits
- Diagnostic lab and X-ray connected with a nonroutine office visit
- Nonelective inpatient services if the plan is notified within 48 hours of admission
- Outpatient services to treat the abuse of or addiction to alcohol or drugs
- Outpatient services to diagnose and/or treat mental conditions
- Short-term rehabilitation services, including physical, occupational and speech therapy. Coverage for physical and occupational therapy is provided for as many visits as are medically necessary per acute episode, within a 90-day period beginning with the first office visit (combined with any in-area visits). Coverage for speech therapy is provided for as many visits as are medically necessary.

All copayments, exclusions and other requirements described on pages 76 to 118 apply to these services.

Aside from emergency care, the services listed above are the only services that are covered for students on an out-of-network basis. All other plan services must be obtained when they return to the plan service area. Services that are not covered for students while out-of-area include:

- Routine physical, gynecological exams, vision screening and hearing screening
- Routine preventive care
- Nonemergency prescription medication. You may use the prescription medication mail-order program to fill medication refills. (See page 102.)
- Second opinion

- Dental or oral surgery care, except for the emergency care described on page 96.
- Chiropractic care services
- Home health care
- Outpatient surgical procedures that could be delayed until returning to the plan service area
- Maternity care or delivery
- Durable medical equipment (e.g., wheelchairs), including maintenance or replacement

General exclusions and limitations

You are not covered for the following services. These are in addition to the exclusions listed in the individual benefit sections of this handbook on pages 76 to 120:

1. Services or supplies that are not described as covered in this *Member Handbook*
2. Services or supplies that are not provided by or authorized by a network provider, plan dentist or the plan, except in the emergency situations described on page 96
3. Services or supplies that are not medically necessary for the prevention, detection or treatment of an illness, injury or disease as determined by a network provider and the plan. Some examples include (but are not limited to): autopsies, routine circumcision performed after an infant's discharge from a maternity admission, ear plugs to prevent fluid from entering the ear canal during water activities, and nutritional supplements or formulas for adults or children unless described on pages 76 to 120 as covered. Services or supplies that do not meet the plan's medical criteria are not considered to be medically necessary.
4. Any experimental procedure or service that is not generally accepted medical practice. (This does not include the off-label uses of covered drugs used in the treatment of HIV/AIDS or cancer, nor bone marrow transplants for breast cancer as required by state law.) This is determined by a plan medical director.
5. Any services furnished by any provider not having a license or approval, under applicable state law, to furnish that type of service
6. Care that we determine is custodial. Custodial care is defined as a level of care which: (a) is chiefly designed to assist a person with the activities of daily life; and (b) cannot reasonably be expected to improve a medical condition.
7. Services furnished to someone other than the member, or incurred with respect to any individual while not a covered person except as specifically provided hereunder
8. Services and supplies received for reasons of preference or convenience

9. Exams or treatment required by a third party unless medically necessary as determined by a plan physician and the plan. Examples are pre-employment or school physicals, premarital medical tests, court-ordered treatment or immunizations required due to your job or work conditions.
10. An illness or injury that we determine arose out of or in the course of your employment
11. Services or supplies associated with care for military-service-connected disabilities for which you are legally entitled to services and for which facilities are reasonably available, or care for conditions that state and local law require be treated at a public facility
12. Services covered under the plan that are performed by a member of your family or household, unless that person is a licensed health care provider who would otherwise have been gainfully employed performing these services
13. Services or supplies related to a transsexual operation
14. Services to reverse a voluntary sterilization
15. Charges that would not have been made if no coverage hereunder existed or that no individual covered under this group contract is legally obligated to pay
16. Acupuncture or massage therapy

A

B

C

D

E

F

G

H

I

K

L

M

N

O

INDEX

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FALLON COMMUNITY HEALTH PLAN

10 Chestnut St. • Worcester, MA • 01608-2810

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ADDENDUM
FCHP Direct Care

This is part of your
Commonwealth of Massachusetts Member Handbook
Form #A2713
Effective July 1, 2004

Thank you for choosing Fallon Community Health Plan's (FCHP) Direct Care for your health care coverage. As a member of FCHP Direct Care, you are required to use the health care professionals and facilities contracted by the plan to provide covered benefits to our FCHP Direct Care members. We call these contracted health care professionals and facilities our FCHP Direct Care network providers. The FCHP Direct Care network includes providers throughout Worcester County, and in parts of Middlesex, Hampden and Norfolk counties. For a complete listing of the communities in the FCHP Direct Care service area, see pages 11 to 12 of this addendum.

This addendum contains information that is specific to the FCHP Direct Care provider network. Please refer to this addendum for the following information:

- Definitions for terms we use in this addendum
- Your costs for covered services as a member of FCHP Direct Care
- The maximum copayment amounts you are responsible for in a calendar year
- A list of services that require plan preauthorization
- The FCHP Direct Care service area
- The amount of the premium charge that is paid on your behalf

Definitions

***FCHP Direct Care network*—**the health care professionals and facilities contracted to provide covered services to members of FCHP Direct Care.

***FCHP Direct Care network provider*—**a licensed physician or other health care professional, or hospital or other health care facility in the FCHP Direct Care network with whom we contract to provide covered services to members of FCHP Direct Care. FCHP Direct Care providers include, but are not limited to, physicians, dentists, chiropractors, optometrists, podiatrists, certified nurse midwives, certified registered nurse anesthetists, nurse practitioners and behavioral health professionals.

***FCHP Direct Care service area*—**the cities and towns listed in the FCHP Direct Care service area on pages 11 to 12 of this addendum.

Your costs for covered services

The following chart shows your costs for covered services. Be sure to refer to the Description of Benefits on pages 76 to 122 of your *Commonwealth of Massachusetts Member Handbook* for a complete description of the covered services and any limitations or exclusions that apply.

Service	Benefit	Page
Ambulance	Covered in full	76
Emergency and urgent care		
1. Emergency room visits	$75 copayment per visit	78
2. Emergency room visits when you are admitted to an observation room	Covered in full	
3. Emergency room visits when you are admitted as an inpatient	Covered in full	
4. Urgent care visits in a provider's office or at an urgent care facility	$10 copayment per visit	

Service	Benefit	Page
Home health care services	Covered in full	80
Hospice care	Covered in full	81
Hospital inpatient services		
1. Inpatient care for as many days as medically necessary, including room and board and the services and supplies that would ordinarily be furnished to you while you are an inpatient	$250 copayment per admission	82
2. Professional services furnished to you while you are an inpatient	Covered in full	
Infertility/assisted reproductive technology services		
1. Office visits for the diagnosis and treatment of infertility	$15 copayment per office visit	84
2. Diagnostic laboratory and X-ray services	Covered in full	
3. Assisted reproductive technology procedures	Covered in full	
Maternity services		
1. Prenatal and postpartum care	*Prenatal:* $10 copayment (first prenatal office visit only) *Postpartum:* $10 copayment per office visit	86

(continued)

Service	Benefit	Page
Maternity services (cont.)		
2. Inpatient care for as many days as medically necessary, including room and board and the services and supplies that would ordinarily be furnished to you while you are an inpatient	$250 copayment per admission	
3. Professional services furnished to you while you are an inpatient	Covered in full	
Mental health services		
Inpatient services		
1. Inpatient care for as many days as your condition requires, including room and board and the services and supplies that would ordinarily be furnished to you while you are an inpatient	Covered in full	88
2. Professional services furnished to you while you are an inpatient	Covered in full	
Intermediate services		
1. Mental health care provided in an alternative setting	Covered in full	
Outpatient		
1. Outpatient office visits, including individual, group or family therapy	$10 copayment per office visit	
2. Psychopharmacological services	$10 copayment per office visit	
3. Neuropsychological assessment services	$10 copayment per office visit	

Service	Benefit	Page
Office visits and outpatient services		
1. Office visits to diagnose or treat an illness or injury	*Primary care provider (PCP):* $10 copayment per office visit *Specialist:* $15 copayment per office visit	*92*
2. Radiation therapy	Covered in full	
3. Injections and injectables	Covered in full	
4. Allergy testing and allergy injections	Covered in full	
5. Diagnostic lab and X-ray services	Covered in full	
6. Renal dialysis	Covered in full	
7. Hearing exam for the purpose of prescribing a hearing aid	$15 copayment per office visit	
8. Diabetic services, including		
• diabetes outpatient self-management training and education	$10 copayment per office visit	
• laboratory tests for the diagnosis and treatment of diabetes	Covered in full	
9. Chiropractic services	$10 copayment per office visit	
10. Medical social services	$10 copayment per office visit	

(continued)

Service	Benefit	Page
Office visits and outpatient services (cont.)		
11. Voluntary family planning services	$10 copayment per office visit	
12. Outpatient surgery	$75 copayment per surgery	
Oral surgery and related services	$15 copayment per office visit	96
Organ transplant		98
1. Office visits related to the transplant	$20 copayment per office visit	
2. Inpatient care for as many days as medically necessary, including room and board and the services and supplies that would ordinarily be furnished to you while you are an inpatient	$250 copayment per admission	
3. Professional services furnished to you while you are an inpatient	Covered in full	
4. HLA testing	Covered in full	
Prescription medication	*Pharmacy:* Tier 1: $5 copayment Tier 2: $20 copayment Tier 3: $60 copayment for up to a 30-day supply *Mail-order:* Tier 1: $10 copayment Tier 2: $40 copayment Tier 3: $180 copayment for up to a 90-day supply	100

Service	Benefit	Page
Preventive care		
1. Periodic physical exams with your PCP for the prevention of disease	$10 copayment per office visit	104
2. Immunizations	Covered in full	
3. A baseline mammogram for women ages 35 to 40, and a yearly mammogram for women age 18 and older	Covered in full	
4. Routine gynecological care services	$10 copayment per office visit	
5. Routine eye exams	$10 copayment per office visit	
6. Hearing and vision screening	Covered in full	
7. Pediatric wellness visits with your child's primary care provider (PCP)	Covered in full	
8. Coronary artery disease, secondary prevention program	$200 copayment	
Prosthetic/orthotic devices and durable medical equipment		
1. The purchase or rental of prosthetic/orthotic devices and durable medical equipment	20% coinsurance	106
2. Hearing aid(s)	The first $500 of the purchase price is covered in full. You pay 20% of the next $1,500 of the purchase price plus all additional costs.	

(continued)

Service	Benefit	Page
Prosthetic/orthotic devices and durable medical equipment (cont.)		
3. Scalp hair prosthesis	20% coinsurance	
4. Oxygen and oxygen-related equipment	20% coinsurance	
5. Breast prosthesis	Covered in full	
Reconstructive and restorative surgery		
1. Office visits related to the surgery	$15 copayment per office visit	109
2. Reconstructive surgery in a hospital outpatient, day surgery or ambulatory care facility	$75 copayment per surgery	
3. Inpatient care for as many days as medically necessary, including room and board and the services and supplies that would ordinarily be furnished to you while you are an inpatient	$250 copayment per admission	
4. Professional services furnished to you while you are an inpatient	Covered in full	
Rehabilitation services		
1. Short-term rehabilitation services, including physical and occupational therapy	$10 copayment per office visit	111
2. Services for the diagnosis and treatment of speech, hearing and language disorders	$10 copayment per office visit	
3. Cardiac rehabilitation	Covered in full	

Service	Benefit	Page
Rehabilitation services (cont.)		
4. Early intervention services	Covered in full	
Skilled nursing facility	Covered in full	113
Special formulas	Covered in full	115
Substance abuse services		116
Inpatient services		
1. Substance abuse detoxification or rehabilitation for as many days as your condition requires, including room and board and the services and supplies that would ordinarily be furnished to you while you are an inpatient	Covered in full	
2. Professional services furnished to you while you are an inpatient	Covered in full	
Intermediate services		
1. Substance abuse services provided in an alternative setting	Covered in full	
Outpatient		
1. Outpatient office visits to treat the abuse of or addiction to alcohol or drugs	$10 copayment per office visit	

Copayment maximum
There is a limit to the amount you must pay in copayments in a calendar year for certain services. This limit applies to all copayments made for medical office visits and oral surgery office visits. **You are responsible for office visit copayments up to a maximum of $150 per member or $250 per family in each calendar year.**

(continued)

The limit to the amount you must pay in medical office visit copayments in a calendar year does not apply to mental health office visits, substance abuse office visits or chiropractic office visits.

You are responsible for mental health and substance abuse office visit copayments up to a maximum of $150 per member or $250 per family in each calendar year.

In addition, you are responsible for a maximum of four (4) inpatient copayments per member in each calendar year, and four (4) outpatient surgery copayments per member in each calendar year.

FCHP will track the copayments that apply to the calendar year limit. When you reach the maximum for any service, we will send you a letter that indicates the date of the last required copayment for that service. For the rest of the calendar year, you may present a copy of the letter to the cashier, who will not take a copayment for the specified services. If you do not bring the letter with you to the appointment, you may be asked to pay the copayment.

If you pay any copayments that you are not responsible for, you may send a letter to the claims manager at FCHP requesting reimbursement of those copayments. Include your name, address, membership number, proof of payment (encounter form, receipt, check, etc.) and an address to which the reimbursement should be sent. You must file a claim within two years of the date of service.

Services that require plan preauthorization

The following covered services require preauthorization from the plan. Preauthorization must be requested by your PCP or, in some cases, your specialist.

- All elective admissions to a hospital or other inpatient facility
- Services with a non-FCHP Direct Care network provider
- Organ transplant evaluation and services
- Reconstructive surgery
- Infertility/assisted reproductive technology services
- Oral surgery (with the exception of the extraction of impacted teeth)

Services that require plan preauthorization (cont.)

- Genetic testing
- Pain clinic
- Neuropsychological testing
- Prosthetics/orthotics and durable medical equipment
- Home health care and hospice care
- Nonemergency ambulance
- PET scans

For additional important information about obtaining specialty care and services, see pages 18 to 20 of your *Member Handbook*.

The FCHP Direct Care service area

The FCHP Direct Care service area includes all of the following cities and towns. Please note that when you are outside of the FCHP Direct Care service area, you are covered for emergency and urgent care services only. If you have an emergency medical condition, you should go to the nearest emergency room or call your local emergency communications system (police, fire or 911). For more information on emergency and urgent care services, see pages 18 to 20 of your *Member Handbook*.

Ashburnham
Ashby
Ashland
Auburn
Ayer
Barre
Bellingham
Berlin
Blackstone
Bolton
Boxborough
Boylston
Brimfield
Brookfield
Charlton
Clinton
Douglas
Dudley
East Brookfield
Fitchburg
Framingham
Franklin
Gardner
Grafton
Groton
Hardwick
Harvard
Holden
Holland
Holliston
Hopedale
Hopkinton
Hubbardston
Hudson
Lancaster
Leicester
Leominster
Littleton
Lunenburg
Marlborough
Maynard
Medfield
Medway
Mendon
Milford
Millbury
Millis
Millville

(continued)

Monson
Natick
New Braintree
Norfolk
North Brookfield
Northborough
Northbridge
Oakham
Oxford
Palmer
Paxton
Pepperell
Petersham
Phillipston
Plainville
Princeton
Rutland
Sherborn
Shirley
Shrewsbury
Southborough
Southbridge
Spencer
Sterling
Stow
Sturbridge
Sudbury
Sutton
Templeton
Townsend
Upton
Uxbridge
Wales
Ware
Warren
Wayland
Webster
West Boylston
West Brookfield
Westborough
Westminster
Winchendon
Worcester
Wrentham

Premium charge

As a Fallon Community Health Plan subscriber, you are enrolled in a health plan that provides comprehensive benefits and quality care. In order to provide this plan for you, the Group Insurance Commission pays Fallon Community Health Plan a monthly premium charge. For the plan year beginning July 1, 2004, and ending June 30, 2005, this amount will be:

$275.73 per month for individual coverage
$661.80 per month for family coverage